IN THE SUPREME COURT

APPEAL FROM THE MICHIGAN COURT OF APPEALS
FITZGERALD, P.J. AND HOEKSTRA AND MARKEY, JJ.

EILEEN HALLORAN, Temporary Personal Representative of the **ESTATE OF DENNIS J. HALLORAN, Deceased,**

Plaintiff-Appellee,

v

RAAKESH C. BHAN, M.D. and **CRITICAL CARE PULMONARY MEDICINE, P.C.,**

Defendants-Appellants

and

BATTLE CREEK HEALTH SYSTEMS,

Defendant.

Supreme Court
No. 121523

Court of Appeals
No. 224548

Calhoun County Circuit Court
No. 98-3953-NH

APPELLANTS' BRIEF ON APPEAL

ORAL ARGUMENT REQUESTED

Submitted by:

Mark A. Bush (P-35775)
Graham K. Crabtree (P-31590)
FRASER TREBILCOCK DAVIS & DUNLAP, P.C.
Attorneys for Defendants-Appellants
Raakesh C. Bhan, M.D., and Critical Care
Pulmonary Medicine. P.C.
1000 Michigan National Tower
Lansing, Michigan 48933
(517) 482-5800

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The trial court has answered this question "No."

The Court of Appeals has answered this question "Yes."

The Defendants-Appellants contend the answer is "No."

Pursuant to the Court's instructions provided in its Order granting leave to appeal, the discussion of this question will address the following specific issues:

1. **WHETHER A STANDARD OF CARE EXPERT WITNESS IS QUALIFIED UNDER MCL 600.2169(1)(a) TO PRESENT EXPERT TESTIMONY AGAINST A DEFENDANT PHYSICIAN WHERE THE PROFERRED WITNESS DOES NOT POSSESS THE SAME BOARD CERTIFICATION AS THE DEFENDANT PHYSICIAN.**

2. **THE PROPER CONSTRUCTION OF THE WORD "SPECIALTY" IN THE FIRST SENTENCE OF MCL 600.2169(1)(a).**

3. **THE PROPER CONSTRUCTION OF THE PHRASE "THAT SPECIALTY"" IN THE SECOND SENTENCE OF MCL 600.2169(1)(a).**

STATEMENT OF FACTS

In this medical malpractice action from the Calhoun County Circuit Court, the Plaintiff Estate has alleged that the death of Dennis Halloran was caused by negligent treatment provided to him at the Defendant Hospital, Battle Creek Health Systems, on September 30, and October 1, 1994. Defendant Raakesh C. Bhan, M.D., who saw Mr. Halloran in the Emergency Room and ordered his admission, is the only physician Defendant in this case. Dr. Bhan has been board certified in internal medicine by the American Board of Internal Medicine ("ABIM"), and has also received a certificate of added qualification in critical care medicine from the ABIM. [1]

When Mr. Halloran presented to the Emergency Department of Battle Creek Health Systems on September 30, 1994, he was in end-stage liver failure, having been diagnosed with cirrhosis and liver failure in May of 1994. Despite the efforts of Dr. Bhan and other health care providers, Mr. Halloran did not survive his disease.

Mr. Halloran was initially evaluated in the Emergency Department by D.L. McDonnell, M.D. Mr. Halloran reported that he had experienced increasing abdominal girth, upset stomach, weakness, and increasing shortness of breath. He acknowledged heavy drinking for the past few days. His previous history included IV drug use, hepatitis, alcohol abuse, and the diagnosis of cirrhosis and liver failure in May of 1994. Mr. Halloran indicated that he had been scheduled to return to the Veterans Administration Hospital in Ann Arbor in

[1] See Dr. Bhan's Curriculum Vitae, submitted to the trial court as Exhibit A of Defendants' Motion to Strike Plaintiff's Expert. (Appendix, pp. 36a – 42a)

August of 1994, but that he had failed to do so. He also reported that he had not been taking medications which had been prescribed to him by his VA physicians.[2]

After performing a thorough history and physical, Dr. McDonnell's impression was that Mr. Halloran was suffering from hepatorenal (liver-kidney) failure, chronic alcohol abuse, and medical non-compliance. Dr. McDonnell requested that Dr. Bhan, a board certified internist practicing intensive care medicine, consult on Mr. Halloran's case. (Appendix, p. 11a)

Mr. Halloran was becoming tachycardic when Dr. Bhan was called to consult. Upon examination, Dr. Bhan noted that Mr. Halloran's respirations were slow and irregular, and it appeared that his state of consciousness was worsening. Based upon these, and other observations, Dr. Bhan immediately ordered that Mr. Halloran be transferred to the Intensive Care Unit. In the Intensive Care Unit, Mr. Halloran's condition deteriorated rapidly. He went into cardiac arrest and, despite all efforts to resuscitate him, he died at 2:10 a.m. on October 1, 1994.[3]

Plaintiff's Complaint has alleged that the Defendants failed to properly assess and treat Mr. Halloran's condition, resulting in cardiac arrest and death. (Appendix, pp. 13a – 26a) The Complaint was supported by an Affidavit of Merit signed by Dr. Thomas J. Gallagher. (Appendix, pp. 25a – 26a) That Affidavit stated that Dr. Gallagher was licensed to practice

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[2] See Battle Creek Health Systems Emergency Department Report, signed by D.L. McDonnell, M.D., submitted to the trial court as Exhibit 4 of Plaintiff's Answer to Defendants' Motion to Strike Plaintiff's Expert. (Appendix, p. 11a)

[3] See Progress Report, signed by R.C. Bhan, M.D. (Appendix, p. 12a) Plaintiff's Notice of Intent, submitted to the trial court as Exhibit "B" of Plaintiff's Complaint, states on page 2 that the records of Mr. Halloran's care were attached thereto, and incorporated by reference therein. (Appendix, p. 19a)

medicine in Florida and that he practiced the specialty of critical care medicine, but did not disclose any board certification.

To establish the basis for Plaintiff's claims against the Defendants in this case, the Complaint relied upon, and incorporated by reference, the allegations set forth in Dr. Gallagher's Affidavit of Merit and the Notice of Intent previously filed pursuant to MCL 600.2912(b). (Appendix, pp. 18a – 24a) Dr. Gallagher's Affidavit of Merit simply endorsed the allegations of negligent treatment which had been made previously in Plaintiff's Notice of Intent. Thus, to determine the basis for Plaintiff's claims in this matter, it is necessary to examine the Notice of Intent filed as Exhibit "B" of Plaintiff's Complaint. The Notice of Intent claimed that Dr. Bhan had breached the standard of care by :

> "(a) Failure to treat renal failure with something other than a 1 mg. dose of Bumex ordered every 8 hours and Aldactone 25 mg. 3 times a day and failure to make provision for failure to respond to that therapy;
>
> "(b) Failure to order treatment for the respiratory distress which was indicated by labored breathing and a respiratory rate greater than 30 per minute;
>
> "(c) Giving Demoral [sic], a narcotic, which was ordered and given at a dose of 25 mg. IM every 3 hours to the patient who was already in respiratory distress;
>
> "(d) Failing to order specific monitoring;
>
> "(e) Failing to attempt to determine the source of and to treat Mr. Halloran's metabolic acidosis;
>
> "(f) Failing to undertake some sort of therapy to correct Mr. Halloran's abnormal clotting factors."
>
> (Appendix, pp. 20a – 21a)

On January 27, 1999, Plaintiff filed an expert witness list in the circuit court, naming Dr. Gallagher as a standard of care expert witness. (Appendix, pp. 45a – 46a)

During his November 4, 1999 deposition, Dr. Gallagher revealed that his board certification was in anesthesiology. He freely acknowledged that he is not certified in internal medicine, as is Dr. Bhan. Dr. Gallagher also acknowledged that he is not board eligible in internal medicine, and has not received training as an internist:[4]

"Q. **And are you board certified in anesthesiology?**

"A. **Yes.**

"Q. **Are you board certified in internal medicine?**

"A. **No.**

"Q. **Are you board eligible in internal medicine?**

"A. **No.**

"Q. **Did you ever train as an internist?**

"A. **No.**"

* * *

"Q. . . . at the risk of being so redundant at the very beginning I want to make sure I have this clear on the record. **You are not board certified in internal medicine, am I correct?**

"A. **Yes.**"

(Appendix, pp. 48a – 49a - Emphasis added)

It is also undisputed, and indeed Dr. Gallagher's own testimony establishes, that no board certification exists for critical care medicine:

"Q. Are you considered board-certified in critical care or is yours a certificate of special qualification?

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[4] See Deposition of Dr. Gallagher. (Appendix, pp. 47a – 49a) Copies of the pertinent pages from Dr. Gallagher's deposition were provided to the trial court as Exhibit C of Defendants' Motion to Strike Plaintiff's Expert.

"A. There is no board certification in critical care or in any specialties. They're all a certificate of special qualification or special competence."

(Appendix, p. 49a)

Thus, the essential facts pertinent to the issues raised in this appeal are not disputed. It is undisputed that Dr. Bhan is board certified in the medical specialty of internal medicine and that Dr. Gallagher, Plaintiff's proffered standard of care expert witness, is board certified in the medical specialty of anesthesiology. It is also undisputed that Dr. Gallagher is not board certified or eligible for board certification in internal medicine, and has not received training as an internist.

As noted previously, Dr. Bhan has been board certified in internal medicine by the American Board of Internal Medicine ("ABIM"), and has also received a certificate of added qualification in critical care medicine from the ABIM. It is undisputed that Dr. Gallagher has been board certified in anesthesiology by the American Board of Anesthesiology ("ABA"), and has received a certificate of added qualification in critical care medicine from the ABA. It is also undisputed that no primary board certification exists for the subspecialty of critical care medicine.[5]

The American Board of Anesthesiology offers a subspecialty certification in critical care medicine. To sit for this examination, a candidate must be a diplomate of the ABA. Certification by an entity other than the ABA will not meet this requirement. Moreover, a candidate for the subspecialty certification must have completed the ABA subspecialty

[5] See Deposition of Dr. Gallagher (Appendix, pp. 48a – 49a)

training requirement and have satisfied the examination requirement for the subspecialty certification.[6] This is the training which Dr. Gallagher has completed.

In contrast, the American Board of Internal Medicine offers a certificate of added qualification in critical care medicine. To sit for this examination, a candidate must have been previously certified in internal medicine by the ABIM, completed requisite training, demonstrated competence in the clinical care of patients, and passed the subspecialty or area of added qualification examination. This is the training which Dr. Bhan has completed.[7]

Upon learning that Dr. Gallagher is not board certified in internal medicine, counsel for Dr. Bhan and his professional corporation, Critical Care Pulmonary Medicine, P.C., filed a motion to strike Dr. Gallagher as Plaintiff's standard of care expert for his inability to satisfy the requirements for qualification of expert witnesses set forth in MCL 600.2169(1)(a).[8] Specifically, the Defendants contended that Dr. Gallagher is not qualified to testify as an expert against Dr. Bhan in this matter because Dr. Bhan is board certified in internal medicine, and Dr. Gallagher is not. They have noted, in this regard, that the ABIM added qualification examination which Dr. Bhan took and passed is entirely different from the one offered by the ABA, and that Dr. Gallagher would not even have been qualified to sit for the ABIM examination, which was based on underlying training and knowledge specific to internal medicine and not possessed by an anesthesiologist.

[6] See ABA critical care subspecialty certification requirements from the ABA website, submitted to the trial court as Exhibit 1 of Defendants' Reply Brief in Support of Motion to Strike Expert. (Appendix, pp. 57a – 58a)

[7] See ABIM's requirements for certificates of added qualification from the ABIM website, submitted to the trial court as Exhibit 2 of Defendants' Reply Brief in Support of Motion to Strike Expert. (Appendix, pp. 59a – 62a)

[8] The motion to strike was joined in by Defendant Battle Creek Health Systems, which also participated as an Appellee in the Court of Appeals.

The motion to strike was argued in the circuit court on November 22, 1999 before the Honorable James C. Kingsley, Circuit Judge. After hearing the arguments of counsel, Judge Kingsley ruled that MCL 600.2169(1)(a) refers to primary specialties offering board certification, and does not include subspecialties for which board certification is not available. Accordingly, because Dr. Bhan and Dr. Gallagher are not board certified in the same primary specialty, Judge Kingsley held that Dr. Gallagher is not qualified to give expert testimony in this matter under MCL 600.2169(1)(a). (Appendix, pp. 78a – 79a)

A written Order Granting Defendants' Motion to Strike Plaintiffs' Expert Witness (Appendix, pp. 83a – 84a) was subsequently entered in the circuit court on December 21, 1999. In addition to granting Defendants' motion to strike, that Order included a provision adjourning trial pending appellate review, and stated the court's finding that the issue involved was "important to the jurisprudence of the state."[9]

The Plaintiff appealed the circuit court's Order of December 21, 1999 to the Court of Appeals by leave granted. (Appendix, p. 85a) In an unpublished Opinion issued on March 8, 2002, the Court of Appeals (by Judges Fitzgerald and Markey) reversed the circuit court's decision and remanded for further proceedings. (Appendix, pp. 86a – 91a) The reversal of Judge Kingsley's decision was based upon the majority's finding that: 1) Dr. Bhan was practicing critical care medicine at the time of the alleged malpractice; 2) the requirements of the statute were satisfied because Dr. Bhan and Dr. Gallagher were both specialists,

[9] The trial court's Order stated that "The Court further finds that the issue raised by the Defendant's motion is important to the jurisprudence of the state, is one on which there is no known appellate decision, is one which is likely to arise in other cases because of the manner in which medicine is practiced today, is one on which the trial courts and counsel may benefit from guidance of the appellate court and establishment of a uniform rule and is one which is important to the trial of this case." (Appendix, p. 84a)

specializing in the subspecialty of critical care medicine; and 3) the board certification requirement contained in the second sentence of MCL 600.2169(1)(a) does not apply in this case because there is no board certification for the subspecialty of critical care medicine. (Appendix, pp. 86a – 89a) Judge Hoekstra dissented, expressing his opinion that the statute's board certification requirement applies in this case, and that "the board certification itself, not the certificate of added or special qualification" was "the defining credential for purposes of analyzing the applicability of the second sentence of section 2169(1)(a)." (Appendix, pp. 90a - 91a)

Dr. Bhan and Critical Care Pulmonary Medicine, P.C. filed a timely Motion for Rehearing in the Court of Appeals on March 29, 2002. The Court of Appeals denied that motion in an Order entered on April 22, 2002. The Court's Order denying rehearing was issued by Judges Fitzgerald and Markey; it states that Judge Hoekstra would have granted the motion. (Appendix, p. 92a)

Defendants-Appellants Raakesh C. Bhan, M.D. and Critical Care Pulmonary Medicine, P.C. subsequently sought leave to appeal the decision of the Court of Appeals to this Honorable Court pursuant to MCR 7.302. The Court entered its Order granting leave to appeal on March 25, 2003. (Appendix, p. 93a)

SUMMARY OF ARGUMENTS

The Court of Appeals majority has concluded that Dr. Gallagher, the Plaintiff's proffered standard of care expert, is qualified to give expert testimony against Dr. Bhan in this case based upon its findings that: 1) Dr. Bhan was practicing critical care medicine at the time of the alleged malpractice; 2) the requirements of MCL 600.2169(1)(a) were satisfied because Dr. Bhan and Dr. Gallagher were both specialists, specializing in the subspecialty of critical care medicine; and 3) the board certification requirement contained in the second sentence of MCL 600.2169(1)(a) does not apply in this case because there is no board certification for the subspecialty of critical care medicine. (Appendix, pp. 86a – 89a)

With all due respect to the Court of Appeals majority, Defendants contend that its conclusions are seriously flawed for a number of reasons. First, by its plain terms, the statute requires that where the defendant physician is a specialist, the proposed expert must have specialized in "the same specialty" at the time of the occurrence forming the basis for the claim. Dr. Gallagher cannot satisfy this requirement. It may be acknowledged that Dr. Bhan and Dr. Gallagher both practice the subspecialty of critical care medicine, as separately defined by their respective certifying medical boards, and that they have each received certificates of added qualification in that area from those boards – the ABA in Dr. Gallagher's case, and the ABIM in the case of Dr. Bhan. The difficulty, however, is that Dr. Bhan's primary area of specialization – the specialty in which he is board certified – is internal medicine. Although well qualified as an anesthesiologist, Dr. Gallagher is not board certified in internal medicine, nor is he eligible for board certification in that specialty, never having received the requisite training as an internist.

Under these circumstances, it is clear that Dr. Gallagher does not specialize in "the same specialty" as Dr. Bhan, and thus, cannot qualify as a standard of care expert under § 2169(1)(a). The Court of Appeals majority has erroneously concluded that Dr. Gallagher specializes in "the same specialty" as Dr. Bhan by focusing its attention solely upon the common subspecialty of critical care medicine, while ignoring the fact that their primary areas of specialization are entirely different. For all of the reasons discussed in greater detail *infra*, the Defendants contend that the term "specialty" in the first sentence of § 2169(1)(a) refers, in each case, to the entire package of the defendant physician's relevant areas of specialization. The defendant's primary area of specialization can never be ignored, as it has been in this case, particularly where, as in this case, a certificate of added qualification in a subspecialty requires board certification in the primary specialty as a prerequisite.

Secondly, the phrase "that specialty" in the second sentence of § 2169(1)(a) clearly refers to the specialty in which the defendant physician is board certified. Thus, in a case such as this, where the defendant physician is board certified in a particular specialty, the second sentence of § 2169(1)(a) requires that the proposed expert also be board certified in that specialty. The Court of Appeals' finding to the contrary, which renders the entire second sentence of § 2169(1)(a) meaningless, is contrary to the intent of the Legislature, and is also at odds with established rules of statutory construction. These issues were correctly decided by the circuit court. Its decision should be reinstated.

LEGAL ARGUMENTS

I. THE PLAINTIFF'S PROFFERED STANDARD OF CARE EXPERT WITNESS IS NOT QUALIFIED UNDER MCL 600.2169(1)(a) TO PRESENT EXPERT TESTIMONY AGAINST THE DEFENDANT PHYSICIAN IN THIS CASE, WHERE THE PROFFERED WITNESS DOES NOT POSSESS THE SAME BOARD CERTIFICATION AS THE DEFENDANT PHYSICIAN.

In Michigan, a proposed expert witness cannot present standard of care testimony in a medical malpractice case unless he or she is able to satisfy the statutory requirements of MCL 600.2169(1), which provides as follows:

> "(1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> > "(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty.
> >
> > "(b) Subject to subdivision (c), during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
> >
> > > "(i) The active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, the active clinical practice of that specialty.
> > >
> > > "(ii) The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against

> whom or on whose behalf the testimony is offered is licensed and, if that party is a specialist, an accredited health professional school or accredited residency or clinical research program in the same specialty.
>
> "(c) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence that is the basis for the claim or action, devoted a majority of his or her professional time to either or both of the following:
>
> > "(i) Active clinical practice as a general practitioner.
> >
> > "(ii) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party against whom or on whose behalf the testimony is offered is licensed."

The Court has granted leave to appeal in this case to construe the language of MCL 600.2169(1)(a), and thereby determine the scope of its requirements. These are questions of statutory construction, questions of law, which are reviewed *de novo*. McClellan v Collar (On Remand), 240 Mich App 403, 409; 613 NW 2d 729 (2000)

A. THE DEVELOPMENT OF THE STATUTORY STANDARDS

Section 2169 was added to the Revised Judicature Act as a part of the tort reform legislation of 1986 -- 1986 P.A. No. 178. As originally enacted, § 2169(1)(a) provided as follows:

> "(1) In an action alleging medical malpractice, if the defendant is a specialist, a person shall not give expert testimony on the appropriate standard of care unless the person is or was a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state and meets both of the following criteria:
>
> > "(a) Specializes, or specialized at the time of the occurrence which is the basis for the action, in the same specialty or a

related, relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant in the medical malpractice action.

"(b) Devotes, or devoted at the time of the occurrence which is the basis for the action, a substantial portion of his or her professional time to the active clinical practice of medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to the instruction of students in an accredited medical school, osteopathic medical school, or dental school in the same specialty or a related, relevant area of health care as the specialist who is the defendant in the medical malpractice action."

The purpose of this provision was twofold – to "make sure that experts will have firsthand practical experience in the subject matter about which they are testifying," and to "protect the integrity of our judicial system by requiring real experts instead of 'hired guns.' " McDougall v Schanz, 461 Mich 15, 25-26 fn. 9; 597 NW 2d 148 (1999) (quoting the Report of the Senate Select Committee on Civil Justice Reform, presented to the Michigan Senate on September 26, 1985)[10]

Thus, as created in 1986, § 2169(1)(a) established, as one of the necessary criteria, that the proposed expert "Specializes, **or specialized** at the time of the occurrence which is the basis for the action, in the same specialty **or a related, relevant, area of medicine or osteopathic medicine and surgery or dentistry** as the specialist who is the defendant in the medical malpractice action." (Emphasis added)

Section 2169 was subsequently amended by the 1993 medical malpractice tort reform legislation (1993 P.A. 78), the principal object of which was to enact further reforms,

[10] The Court's decision in McDougall incorrectly states that the quoted report was issued on September 26, 1995. This report, which was, in large part, the impetus for the enactment of the 1986 tort reforms, was in fact presented to the Michigan Senate on September 25, 1985. Copies of the pertinent parts of that report are attached as Appendix "A."

expanding and improving upon those enacted in 1986.[11] The amendments effected by that legislation eliminated the above-emphasized provisions. Thus, it must now be shown that the proposed expert "specializes" (the Legislature obviously meant "specialized")[12] in the same specialty as the defendant physician at the time of the occurrence giving rise to the action. This was not required before. Under the statute as originally enacted, it was sufficient if the proposed expert was currently specializing in the same specialty **or** specialized in that specialty at the time of the occurrence. Also eliminated, was the language allowing the proposed expert to specialize, or have specialized, in a "related, relevant, area of medicine or osteopathic medicine and surgery or dentistry." Now, it is necessary for the witness to have specialized in "the same specialty" at the time of the occurrence. Specialization in a "related, relevant area" will no longer suffice.

The 1993 legislation also tightened the qualifications for expert witnesses by requiring that the proposed expert witness be currently licensed to practice medicine. As originally enacted, the statute required a showing that the proposed expert "is **or was** a physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry in this or another state." Thus, it was possible to present an expert who was no longer licensed to practice medicine. This, also, has been changed by the elimination of the above-emphasized language.

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[11] The Defendants would direct the Court's attention to the Senate Fiscal Agency's analysis of 1993 P.A. 78 (Enrolled Senate Bill 270) and the House Legislative Analysis Section's analysis of the House substitutes for Senate Bill 270, copies of which are attached as Appendices "B" and "C" respectively.

[12] As the above highlighted excerpt illustrates, the 1993 legislation eliminated "or specialized" after "Specializes," improperly leaving a present tense verb to refer to a past event – the proposed expert's specialization "at the time of the occurrence which is the basis for the action."

The statutory requirements for qualification of expert witnesses were also tightened considerably by the addition of the second sentence of § 2169(1)(a), which now imposes an additional requirement that, when the defendant physician is board certified in a specialty, the proposed expert witness must also be board certified in "that specialty." With all of these important changes, § 2169(1)(a) now provides as follows:

> "(1) In an action alleging medical malpractice, a person shall not give expert testimony on the appropriate standard of practice or care unless the person is licensed as a health professional in this state or another state and meets the following criteria:
>
> > "(a) If the party against whom or on whose behalf the testimony is offered is a specialist, specializes at the time of the occurrence that is the basis for the action in the same specialty as the party against whom or on whose behalf the testimony is offered. However, if a party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified in that specialty."

B. THE FIRST SENTENCE OF MCL 600.2169(1)(a) REQUIRES A PRECISE MATCH OF RELEVANT SPECIALTIES AND SUBSPECIALTIES.

In its present form, the first sentence of § 2169(1)(a) requires that when the defendant physician is a specialist, as Dr. Bhan clearly is, the plaintiff must show that his proposed expert has specialized in "the same specialty" as the defendant physician at the time of the occurrence that is the basis for the action. As noted previously, this requirement of specialization in "the same specialty" is much more specific than the standard imposed under the original statute. It no longer suffices to show that the proposed expert is a specialist in "a related, relevant area of medicine or osteopathic medicine and surgery or dentistry." Nor will it suffice to show that the proposed expert has specialized in "a substantially similar

specialty." Language to this effect was considered in the legislative process, but ultimately rejected.[13]

The Legislature has not defined "specialty," either in the original legislation, or the 1993 amendments. Because "specialty" has not been specially defined, its meaning must be "construed and understood according to the common and approved usage of the language." MCL 8.3a.[14] Additionally, pursuant to MCL 8.3b, the singular "specialty" may also be interpreted to include the plural "specialties."[15] Finally, in the absence of a statutory definition, it is also appropriate to consider dictionary definitions to aid the Court in determining the meaning of "specialty" in accordance with its ordinary and generally accepted meanings. In Re Certified Question from the United States Court of Appeals for the Sixth Circuit, ___ Mich ___; ___ NW 2d ___ (No. 120110 *rel'd* 4-23-2003); Decker v Flood, 248 Mich App 75, 83; 638 NW 2d 163 (2001)

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[13] In the House of Representatives, the Judiciary Committee reported a Bill Substitute (H-1) for Senate Bill 270, which would have allowed standard of care testimony from a proposed expert who had specialized in "a substantially similar specialty." Copies of the pertinent portions of that Bill Substitute are attached as Appendix "D." The Bill Substitute (H-1) was adopted by the full House of Representatives on the Order of Second Reading of Bills on April 21, 1993, but was superseded shortly thereafter by the adoption of a Bill Substitute (H-2). *See*: 1993 House Journal, pp. 727, 897-899. The Bill Substitute (H-2) included the language which appears in the statute today.

[14] MCL 8.3a provides that "All words and phrases shall be construed and understood according to the common and approved usage of the language; but technical words and phrases, and such as may have acquired a peculiar and appropriate meaning in the law, shall be construed and understood according to such peculiar and appropriate meaning."

[15] MCL 8.3b provides, in pertinent part, that "Every word importing the singular number only may extend to and embrace the plural number, and every word importing the plural number may be applied and limited to the singular number."

In Decker v Flood, *supra*, the Court of Appeals determined, for purposes of § 2169(1)(c), that a "general practitioner" is a physician who is not a specialist. Quoting from the Random House Webster's College Dictionary (1997), the court noted that the term "specialist" is defined as "a medical practitioner who deals only with a particular class of diseases, conditions, patients, etc." The court also noted the definition of "specialist" in Stedman's Medical Dictionary (Twenty-Sixth Ed.), as "one who devotes professional attention to a particular specialty or subject area."

The term "specialty" is broadly defined by the Merriam Webster's College Dictionary (Tenth Ed.) as "something in which one specializes." It is also broadly defined by Dorland's Illustrated Medical Dictionary (Twenty-Fifth Ed.) as "the field of practice of a specialist." Similarly, Schmidt's Attorney's Dictionary of Medicine (Matthew Bender) defines "specialist" as "a medical practitioner who limits his practice to certain diseases, or to the diseases of a system of organs * * *; a person who is a diplomate of one of the specialty boards; a person skilled in a particular science" and broadly defines "specialty" as "the practice pursued by a specialist."

Although "specialty" has not been defined in § 2169(1)(a), the statutory language clearly suggests that its meaning must be determined in relation to the defendant physician's area or areas of specialization. The language plainly requires a showing that the proposed expert has specialized "in the same specialty as the party against whom or on whose behalf the testimony is offered." Defining "specialty" by reference to the defendant physician's area or areas of specialization is consistent with this language, and is also fully consistent with the statute's purpose of ensuring that the proposed expert has the necessary training and experience to give standard of care testimony against the defendant physician.

It is also consistent with this purpose to require a precise match of all of the defendant physician's relevant specialties and subspecialties. As this, and other similar cases have illustrated, it is a fact of life in the modern-day practice of medicine that a physician may be engaged in the practice of more than one specialty. It is not uncommon to find physicians who are board certified in two or more specialties or subspecialties, or to find others who, like Dr. Bhan, are board certified in one primary specialty with a certificate of added qualification in a related subspecialty for which there is no board certification. In such cases, the proposed expert witness should possess the same credentials as the defendant physician. If he does not, it cannot truly be said that he has specialized in "the same specialty." This would appear to be particularly true in a case such as this, where board certification in the specific primary specialty is a prerequisite for the certificate of added qualification in the subspecialty.

This sensible interpretation is not at all inconsistent with the statutory language. As noted previously, it is a well established statutory rule of construction that a singular term may properly be construed to include the plural, and thus, the term "specialty" as used in § 2169(1)(a) may also embrace multiple "specialties." It appears that this may have been overlooked by the Court of Appeals majority, which seems to have felt some compulsion to identify a single "specialty."[16]

The construction adopted by the Court of Appeals majority – that "the same specialty" may consist solely of a separate subspecialty being practiced at the time of the occurrence, despite dramatic differences in the primary areas of specialization – is inconsistent with the

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[16] The Court of Appeals majority quoted a passage from its prior decision in Tate v Detroit Receiving Hospital, 249 Mich App 212; 642 NW 2d 346 (2002), which cited the Legislature's use of the word "specialty," as opposed to "specialties" in support of its holding that "the specialty requirement is tied to the occurrence of the alleged malpractice and not unrelated specialties that a defendant may hold." (Appendix p. 88a)

Legislature's evident intent to more narrowly focus the statute's requirements for qualification of expert witnesses in medical malpractice cases.

C. THE COURT OF APPEALS MAJORITY HAS ERRONEOUSLY DEFINED THE RELEVANT "SPECIALTY" IN RELATION TO THE ALLEGED MALPRACTICE.

The Court of Appeals majority has incorrectly concluded that the definition of the "specialty" at issue is tied to the occurrence of the alleged malpractice instead of the defendant physician's areas of specialization. It appears that this conclusion was based solely upon its recent decision in Tate v Detroit Receiving Hospital, 249 Mich App 212; 642 NW 2d 346 (2002). On page 4 of its Opinion in this case, the majority stated that:

> "As stated in *Tate*, *supra*, slip op at 4, "specialty" as it is used in MCL 600.2169(1)(a) is tied to the occurrence of the alleged malpractice and not the unrelated specialties that the physician may possess. Thus, contrary to defendant's assertion, the second sentence of § 2169(1)(a), which states that "if the party against whom or on whose behalf the testimony is offered is a specialist who is board certified, the expert witness must be a specialist who is board certified *in that specialty,*" refers to the critical care specialty that serves as the basis for the action and not the specialty of internal medicine."

(Appendix, p. 89a)

This reference to Tate appears to refer to the excerpt of the court's opinion in that case cited on page 3 of the majority's Opinion (Appendix, p. 88a), which states that "The use of the phrase 'at the time of the occurrence that is the basis for the action' clearly indicates that an expert's specialty is limited to the actual malpractice." The Defendants contend that the majority's reliance upon this statement from Tate has been misplaced for a number of reasons.

First, the Tate panel's interpretation of the statutory language is erroneous. The language of the statute simply does not say what the Tate panel has said it does. Its construction of the statute improperly depends upon the insertion of additional language –

specifically, "the specialty being practiced at the time of the occurrence" – into the statute in reference to the requirement for specialization in "the same specialty." This was erroneous. The reading in of additional language that the Legislature could have used, but did not, is plainly at odds with the well established rule of statutory construction that courts "eschew the insertion of words in statutes." Courts will only insert words into a statute in very rare circumstances, when necessary to give intelligible meaning or to avoid absurdity. Empire Iron Mining Partnership v Orhanen, 455 Mich 410, 424; 565 NW2d 844 (1997); MESC v General Motors Corp., 32 Mich App 642, 646; 189 NW2d 74 (1971); Great Lakes v Employment Security Commission, 6 Mich App 656, 661; 150 NW2d 547 (1967). In light of this long-standing aversion to insertion of additional language, this Court has often emphasized that it is loath to "rewrite or embellish" statutory language. Byker v Mannes, 465 Mich 637, 646-647; 637 NW 2d 210 (2002); Olemchuk v City of Warren, 461 Mich 567, 575; 609 NW 2d 177 (2000)

The Defendants submit that this rewriting of the statute was inappropriate, and indeed, amounts to improper judicial legislation. Michigan's appellate decisions have often noted that statutes must generally be applied as written, and that fundamental changes should be effected, not by judicial interpretation, but by appropriately enacted legislation. *See:* People v McIntire, 461 Mich 147, 155-158; 599 NW2d 102 (1999); Paulitch v Detroit Edison Co., 208 Mich App 656, 662-663; 528 NW2d 200 (1995), *lv granted*, 451 Mich 899 (1996); *order granting leave vacated*, 453 Mich 967 (1996); Department of Transportation v Thrasher, 196 Mich App 320; 493 NW2d 457 (1992), *aff'd*, 446 Mich 61; 521 NW2d 214 (1994); People v Guthrie, 97 Mich App 226; 293 NW2d 775 (1982).

Moreover, the requirement for the expert to have specialized in the same specialty at the time of the occurrence does not suggest that "an expert's specialty is limited to the actual malpractice" as the Tate panel has concluded. The legislative history of this provision clearly suggests that the purpose of this requirement was, instead, to ensure that the proposed expert witness has the required knowledge of the standard of care applying at the time of the alleged malpractice.

As noted previously, the statute originally enacted in 1986 established, as one of the necessary criteria, that the proposed expert "Specializes, **or specialized** at the time of the occurrence which is the basis for the action, in the same specialty **or a related, relevant, area of medicine or osteopathic medicine and surgery or dentistry** as the specialist who is the defendant in the medical malpractice action." (Emphasis added) The 1993 legislation eliminated the above-emphasized provisions. Thus, it must now be shown that the proposed expert specialized in "the same specialty" as the defendant at the time of the occurrence giving rise to the action.

It is evident that the language of the originally enacted statute was not intended to define the relevant "specialty" by reference to the time of the occurrence; under the original statute, the time-frame could be either past or present. Before 1993, it was sufficient if the proposed expert was currently specializing in the same specialty **or** specialized in that specialty at the time of the occurrence. What, then, was the Legislature's purpose in enacting the amendments to this section in 1993? As noted previously, these changes were obviously intended to tighten up expert witness qualifications for medical malpractice cases. The requirement that the witness have specialized in the same specialty at the time of the alleged malpractice ensures that the witness will be acquainted with the standard of care as it was at

the time. This purpose has also been served by the elimination of the language allowing standard of care testimony by witnesses who have specialized in other "related, relevant areas of medicine or osteopathic medicine or surgery or dentistry," and by the provisions of § 2169(1)(b), which now require a showing that the proposed expert has devoted a majority of his or her professional time to the clinical practice and/or teaching of the same specialty during the year immediately preceding the occurrence forming the basis for the claim.

To qualify a proposed standard of care expert under the current statute, the proponent must show that the expert practiced "the same specialty" at the time of the occurrence. This has served to disqualify many experts who might have been qualified under the original provision, and this was clearly the Legislature's intent.

It may be acknowledged that in Tate, the connection with the alleged malpractice made some sense, while the particular facts that made this so in Tate do not appear in this case, as Judge Hoekstra has aptly noted in his dissenting opinion. In Tate, the defendant physician and the proposed expert were both board certified in the same specialty – the specialty being practiced – but it was claimed that the expert did not qualify because the defendant was certified in other specialties unrelated to the occurrence at issue. Concentration on the nature of the malpractice at issue made sense under those circumstances, and did not offend the statute, because the defendant physician and the plaintiff's expert were both board certified in the specialty being practiced in relation to the allegedly negligent treatment. The same cannot be said in this case, where Dr. Bhan and Dr. Gallagher are board certified in different specialties, there is no board certification in the subspecialty involved, and it cannot be said that the treatment at issue was unrelated to the practice of Dr. Bhan's primary specialty of internal medicine.

It would have been more appropriate for the court to hold, in Tate, that the statute was never intended to require specialization or board certification in a separate specialty that has no relevance to the treatment at issue, and that to impose such a requirement would promote an absurd and unintended result. Although, as noted previously, the term "specialty" in § 2169(1)(a) may properly refer to multiple specialties and/or subspecialties, and thus, the statute should require specialization and, if applicable, board certification, in all specialties and subspecialties practiced by the defendant physician, it may be acknowledged that requiring specialization or board certification in an entirely unrelated specialty is unwarranted. For example, it would clearly be unnecessary and unreasonable, under the circumstances of this case, to require an expert board certified in obstetrics and gynecology if Dr. Bhan happened to also be board certified in that specialty. The same might be said if Dr. Bhan had also become board certified in psychiatry or orthopedics, since neither of those specialties could have had any possible relevance to the treatment provided in this case.

The Defendants respectfully suggest, however, that such exceptions should be recognized and applied sparingly. When a defendant physician practices more than one specialty and/or subspecialty, the expert who testifies against him, or on his behalf, should possess the same credentials unless it can be confidently determined that one or more of the defendant's specialties or subspecialties has no possible relevance to the medical treatment in question. There is no basis for such an exception in this case, where the practice of Dr. Bhan's primary specialty and subspecialty are inextricably intertwined.

D. THE COURT OF APPEALS MAJORITY HAS ERRONEOUSLY DETERMINED THAT THE BOARD CERTIFICATION REQUIREMENT IN THE SECOND SENTENCE OF MCL 600.2169(1)(a) DOES NOT APPLY IN THIS CASE.

Having erroneously determined that the "specialty" involved in this matter is limited to the common subspecialty of critical care medicine, for which there is no board certification, the Court of Appeals majority has determined that the statute's board certification requirement simply does not apply. Again, with all due respect to the Court of Appeals majority, the Defendants contend that this was manifestly erroneous. The majority's construction of MCL 600.2169(1)(a) is clearly contrary to the intent of the Legislature, and is also at odds with well established rules of statutory construction.

Based upon its prior holding in Tate, the Court of Appeals majority has, in essence, read additional language – specifically "the specialty being practiced at the time of the occurrence" -- into the second sentence of § 2169(1)(a) in place of "that specialty." This interpretation suffers from the same infirmity previously discussed – that courts must refrain from reading additional language into a statute.

Furthermore, even if the Tate panel's interpretation of the "the same specialty" in the first sentence of subsection (1)(a) were correct, Tate should not be deemed controlling in this case because it is not appropriate to apply that meaning to define "that specialty" in the second sentence. To do so is contrary to the obvious intent of the 1993 legislation which added the second sentence, and also runs afoul of established rules of construction.

The new second sentence of § 2169(1)(a) has created a separate and more restrictive requirement which applies whenever the defendant physician is board certified, regardless of what the relevant "specialty" is found to be for purposes of the first sentence. This is clearly suggested by the Legislature's use of "However," to introduce its subject matter.

Moreover, the reference to "that specialty" in the second sentence of § 2169(1)(a) obviously refers back to the specialty that the defendant is board certified in. This construction is fully consistent with the statutory language and established rules of construction. Statutory language must be read and understood in its grammatical context, unless it is clear that a different meaning was intended. In Re Certified Question from the United States Court of Appeals for the Sixth Circuit, *supra*; Sun Valley Foods Co. v Ward, 460 Mich 230, 237; 596 NW 2d 119 (1999). It is "an unquestioned rule of grammar, which has been crystallized into a legal maxim, that relative words must ordinarily be referred to the next antecedent where the intent, upon the whole instrument, does not appear to the contrary." Northville Coach Line, Inc. v City of Detroit, 379 Mich 317, 331; 150 NW2d 772 (1967) City of Traverse City v Township of Blair, 190 Mich 313, 323-324; 157 NW 81 (1916). *Accord*: Sun Valley Foods Co., *supra*, 460 Mich at 237.

In the second sentence of § 2169(1)(a), the initial reference to board certification – the reference, earlier in the second sentence, to "a specialist who is board certified" – necessarily suggests that the specialty referred to is the specialty in which the defendant specialist is board certified. Thus, the next antecedent of "that specialty" at the end of that sentence would be the specialty that the defendant was board certified in. Referring back to the preceding sentence to determine the meaning of "that specialty" in the second sentence violates this well established rule of construction.

The Court of Appeals majority's construction of the statute also runs afoul of the well known rule that, in construing a statute, the courts must make every effort to give meaning to every part of it and avoid rendering any part nugatory. State Bar of Michigan v Galloway, 422 Mich 188; 369 NW2d 839 (1985). Seeming inconsistencies in various provisions of a statute

should be reconciled so as to arrive at a meaning which gives effect to all parts of the statute. Petition of Michigan State Highway Commission v Canton Township, Wayne County, 383 Mich 709; 178 NW2d 923 (1970)

In this case, the Court of Appeals majority has concluded that the statute's board certification requirement simply does not apply at all in this, or any other case where there is no board certification available for a discrete subspecialty being practiced in relation to the treatment at issue. Thus, the majority's construction has rendered this part of the statute completely meaningless as applied to this, and other similar cases, and it has done so without any evidence that this was intended. Typically, if the Legislature intends to preclude application of a statutory requirement in a particular circumstance or circumstances, it expresses its intent to do so by use of appropriate language – "Unless ..." or "Except as provided ..." or "provided, however ...," for example. It has not done so here.

Again, the Court should recall that the second sentence of subsection (1)(a) was added by the 1993 medical malpractice tort reform legislation, the principal object of which was to enact further reforms, expanding and improving upon those enacted in 1986, to provide additional protection for the medical profession from the burdens of meritless malpractice litigation. This provision requires, without exception, that if the defendant physician is a specialist who is board certified, the expert witness must also be board certified "in that specialty." Requiring the expert to be board certified in the same specialty that the defendant physician is board certified in is fully consistent with the overall purpose of the 1993 legislation. It is reasonable to assume that if the Legislature had intended to create any exceptions to this requirement, it would have said so, and would have specifically identified the circumstances in which the exception or exceptions would apply.

It is clear, for all of these reasons, that the requirement of board certification established in the second sentence of § 2169(1)(a) – a requirement which applies only where the defendant physician is board certified in a specialty – simply makes no sense if the "specialty" referred to means some other specialty or subspecialty. In this case, the statute clearly requires an expert who is board certified in internal medicine. Dr. Gallagher is not board certified in that specialty, and thus, he is unqualified to present standard of care testimony in this case.

E. THE COURT OF APPEALS MAJORITY HAS ERRONEOUSLY CONCLUDED THAT PLAINTIFF'S PROFFERED EXPERT IS QUALIFIED UNDER MCL 600.2169(1)(a) TO PROVIDE STANDARD OF CARE TESTIMONY IN THIS CASE.

Dr. Bhan is the only physician defendant involved in this case. It is undisputed that Dr. Bhan is board certified in internal medicine. It is also undisputed that Dr. Gallagher, the physician selected by Plaintiff and proposed as a standard of care expert in this case, is **not** board certified, or even board eligible in internal medicine. Nor has he received any training as an internist. All of this was freely acknowledged by Dr. Gallagher during his November 4, 1999 deposition. It is also undisputed, and indeed Dr. Gallagher's own testimony confirmed, that no board certification exists for critical care medicine.

In light of these acknowledgments, it is clear that Dr. Gallagher cannot qualify under MCL 600.2169(1)(a) to provide standard of care testimony against Dr. Bhan, a board certified internist, and therefore, was properly stricken as a proffered standard of care expert witness by the trial court.

Plaintiff's basic argument has been that the subspecialty of critical care medicine should be the measuring stick used to compare Dr. Gallagher and Dr. Bhan, even though (1)

no primary board certification exists for critical care medicine; and (2) § 2169(1)(a) specifically refers to board certified specialties. For all of the reasons previously discussed, the Defendants contend that the trial court properly looked to the recognized medical specialties in which the two doctors do possess board certifications, internal medicine in the case of Dr. Bhan and anesthesiology in the case of Dr. Gallagher. Although Dr. Bhan and Dr. Gallagher have each received certificates of additional qualification in critical care medicine from their respective medical boards, their credentials and training are very different, and thus, it cannot be said that they have specialized in "the same specialty" as the first sentence of § 2169(1)(a) requires.

Apart from Dr. Gallagher's subspecialty certification in critical care, a comparison of his background, training, and qualifications establishes that he is simply not qualified to give standard of care testimony against Dr. Bhan. Internal medicine and anesthesiology are two separate and distinct branches of medicine, each having its own residency programs, training requirements, board certifications, continuing medical education, authoritative journals and other unique characteristics.

Dr. Gallagher's specialty board, the American Board of Anesthesiology, offers a subspecialty certification in critical care medicine. To sit for this examination, a candidate must be a diplomate of the ABA, *i.e.*, a board certified anesthesiologist. Certification by an entity other than the ABA will not meet this requirement. Furthermore, a candidate must have completed the ABA subspecialty training requirement and have satisfied the examination requirement for the subspecialty certification. (Appendix, pp. 57a – 58a) **Accordingly, Dr. Bhan would not even be eligible to sit for the examination which Dr. Gallagher took and passed**.

Conversely, Dr. Bhan's specialty board, the American Board of Internal Medicine, offers a certificate of added qualification in critical care medicine. To sit for this examination, a candidate must have been previously certified in internal medicine by ABIM, completed the requisite training, demonstrated competence in the critical care of patients, and passed the subspecialty or area of added qualification examination. (Appendix, pp. 59a – 62a) **Accordingly, Dr. Gallagher would not even qualify to sit for this examination -- the examination which Dr. Bhan took and passed.**

Thus, it is readily apparent that each of the subspecialty certifications which exists in these two entirely separate and distinct medical specialties are premised upon entirely different underlying training, experience, and knowledge, as measured by the different underlying board certifications. An anesthesiologist simply is not an internist. Thus, the trial court correctly applied § 2169(1)(a) as it was plainly written, and properly declined Plaintiff's invitation to lump together, for purposes of all-important standard of care testimony, two physicians who have entirely different training, clinical backgrounds, and board certifications.

The Court should note, in this regard, that the holding of the Court of Appeals majority has been based, in part, upon unsupported assumptions concerning the relevant facts and the scope of the issue presented. The majority stated, on page 4 of its Opinion (Appendix, p. 89a), that **"Similarly, the alleged malpractice in the instant case that serves as the basis for the action involves critical care medicine and not other specialties in which Gallagher and defendant are certified."** (Emphasis added) In the same vein, the Court also stated, on page 4, that "The fact that Dr. Gallagher lacks a board certification in internal medicine is irrelevant because **plaintiff has not alleged malpractice against defendant for treatment rendered by defendant acting as an internist**." (Emphasis added)

These assumptions are not supported by the record in this case. As the Defendants have noted previously, Defendant Bhan and the Plaintiff's expert are each board certified in very different specialties. Neither has been trained for, or could qualify for certification in, the specialty in which the other has been board certified. Dr. Bhan has practiced as an internist, who also happens to have additional demonstrated competence in critical care medicine. Thus, it is by no means clear that Dr. Bhan was not also practicing his specialty in internal medicine at the time of the occurrence giving rise to this litigation. Indeed, it is far more reasonable to assume the contrary under the circumstances of this case. An internist is "a physician who treats the ailments of the internal organs and structures." Schmidt's Attorney's Dictionary of Medicine (Matthew Bender) This is precisely what Dr. Bhan was doing in this case.

As noted previously, Mr. Halloran was found to be suffering from hepatorenal (liver-kidney) failure when he presented to the Emergency Department on September 30, 1994. It was this condition which required treatment, and which, unfortunately, led to the cardiac arrest which ultimately caused his death. Treatment of this condition was clearly the province of an internist, and the Plaintiff has alleged that Dr. Bhan breached the standard of care by failing to do so properly. An anesthesiologist performs a different function. An anesthesiologist is "a specialist in the science of anesthetics; one who is an expert in the administration of anesthetics. A physician who specializes in anesthesiology." Schmidt's Attorney's Dictionary of Medicine (Matthew Bender)

Thus, although an anesthesiologist may also be involved in critical care, it is likely that his function in that context will generally be different from the function performed by an internist in the treatment of a critically ill patient. When Mr. Halloran was found to be

gravely ill upon presentation in the Emergency Department, Dr. McDonnell did not summon an anesthesiologist. He summoned Dr. Bhan, and his reasons for doing so are obvious. For effective treatment of his disease, Mr. Halloran needed an internist skilled in critical care, not anesthesia.

Dr. Gallagher could not practice as an internist. Although it appears that he, also, has demonstrated training and skill in critical care medicine, he has not been trained or certified as an internist. Thus, he lacks the requisite qualifications to provide standard of care testimony against an internist. It is not at all unreasonable to assume that an internist might treat a patient differently than an anesthesiologist would in a critical care context, and the record in this case contains nothing to prove otherwise. This, also, is a sufficient reason to construe subsection (1)(a) in accordance with its plain terms to require that where a defendant physician is board certified, the Plaintiff's expert must also be board certified in the same specialty that the defendant physician is board certified in.

F. CONCLUSION

For all of the foregoing reasons, The Defendants-Appellants contend that MCL 600.2169(1)(a) has been grievously misconstrued by the Court of Appeals majority. The Court of Appeals has overlooked the plain meaning of the statutory language and the apparent legislative intent underlying the adoption and subsequent amendment of this provision. Its strained interpretation is contrary to the accepted rules of construction, and requires judicial insertion of language which the Legislature could have used, but did not. This Court has frequently emphasized that legislating is a function which should be left to the Legislature. The Court of Appeals has overlooked this essential principle in this case. Its erroneous decision should therefore be reversed, and the decision of the trial court reinstated.

RELIEF

WHEREFORE, Defendants-Appellants Raakesh C. Bhan, M.D. and Critical Care Pulmonary Medicine, P.C. respectfully request that this Honorable Court reverse the decision of the Michigan Court of Appeals and reinstate the trial court's Order Granting Defendants' Motion to Strike Expert Witness.

Respectfully submitted,

Fraser Trebilcock Davis & Dunlap, P.C.
Attorneys for Defendants - Appellants
Raakesh C. Bhan, M.D. and Critical Care
Pulmonary Medicine, P.C.

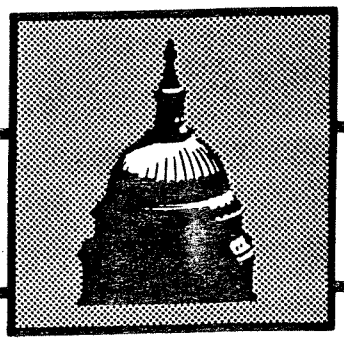
By: _____

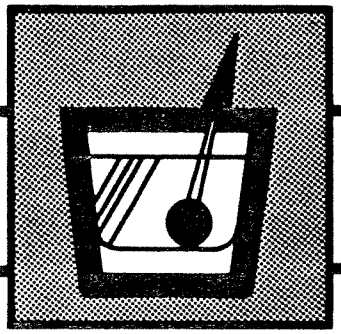
Mark A. Bush (P-35775)
Graham K. Crabtree (P-31590)
1000 Michigan National Tower
Lansing, Michigan 48933
(517) 482-5800

Dated: May 20, 2003

APPENDIX A

REPORT OF THE SENATE SELECT COMMITTEE ON CIVIL JUSTICE REFORM.





Government Liability
Medical Malpractice
Dramshop Reform

THE SENATE SELECT COMMITTEE ON

CIVIL JUSTICE REFORM

A REPORT ON CIVIL JUSTICE IN MICHIGAN

Presented to the Michigan Senate
September 26, 1985

4755

THE SENATE SELECT COMMITTEE ON CIVIL JUSTICE REFORM

The Senate Select Committee on Civil Justice Reform was created by Senate Resolution No. 204 to study civil justice in Michigan.

The Select Committee consists of seven members of the Senate. The Committee is chaired by Senator Dan DeGrow. The other members are Senator Richard Posthumus, Senator Alan Cropsey, Senator Richard Fessler, Senator Lana Pollack, Senator Basil Brown, and Senator Patrick McCollough.

The Select Committee determined that it should be divided into three subcommittees: a subcommittee on medical malpractice, a subcommittee on governmental liability, and a subcommittee on dram shop.

The subcommittee on medical malpractice is chaired by Senator Alan Cropsey; the subcommittee on governmental liability is chaired by Senator Richard Posthumus; and the subcommittee on dram shop is chaired by Senator Richard Fessler.

Pursuant to Senate Resolution No. 204, the select committee was charged with the responsibility "to address, at a minimum, the issues of structured settlements, statutes of limitation, prejudgment interest, joint and several liability, caps on non-economic damages, and the collateral source rule" and to make a report of its findings and recommendations in writing to the Senate as a whole by October 15, 1985. The resolution directed that the Select Committee be staffed by the Office of the Majority Counsel and other Senate staff members as deemed necessary.

This report is submitted in fulfillment of that responsibility.

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-- INTRODUCTION --

"I'll sue!" has become such a standard response to controversy that Michigan court dockets are backlogged, lawsuit counts are mushrooming, awards are setting records and the general public is being seriously affected in both tangible and intangible ways. Reduced access to full health care services, higher property taxes, reduced local government services, a battered business climate and cost-prohibitive liability insurance affects every citizen.

Liability has reached epidemic proportions and presents an emergency situation to the Legislature. There is little time for delay in addressing this crisis. Because of this looming consumer problem, the Senate Select Committee on Civil Justice Reform has conducted public hearings around the state of Michigan this summer to evaluate the extent of the liability problem and seek insights from the experts in devising legislative solutions.

The Select Committee consisted of three subcommittees addressing three major aspects of the problem: Medical Malpractice, Governmental Liability, and Dram Shop Liabiity. Though virtually every other business concern -- from day-care centers to horseback riding stables to law practices -- is affected by liability or malpractice costs, doctors, bar owners and civil governments face perhaps the biggest challenges of the day.

Before legislative findings and solutions are presented in this report of the Senate Select Committee on Civil Justice Reform, a description of the problem in its three specific topic areas is presented in this introduction.

MEDICAL MALPRACTICE

At one time it was seen as a simple turf war between doctors and lawyers, but today the medical malpractice liability crisis is accepted as a grave reality. Its effects reach much further than the medical and legal professions, and it is the patient who suffers most. The main concern is that the increase in medical malpractice premiums is endangering the availability and affordability of health care.

Those needing high-risk care, the poor and uninsured, and those living in inner cities and rural areas are the first to suffer. In some areas, according to public testimony, Medicaid does not even pay out enough to cover the malpractice insurance on certain procedures, let alone the procedure itself.

One witness at a Senate public hearing on this issue stated the problem succinctly: "Nobody cares about the doctors and their pocketbook issues. Nobody cares about the insurance companies. Nobody cares about the lawyers. But when you go to the hospital and you need a bone set and the orthopedic surgeon won't touch you because you're too mangled and he's afraid you're going to sue him, then somebody cares."

The crisis has reached that level already. A recent survey conducted by Martin Block of Michigan State University unearthed startling statistics. Among them: In the past five years, 42 percent of Michigan's family physicians have stopped delivering babies or reduced the number of deliveries; 57.6 percent of family physicians stopped or plan to decrease their involvement in surgery; and 57.3 percent have or plan to reduce their level of involvement in intensive care services.

Other related developments are raising the consciousness of patients. Doctors are refusing to perform certain emergency procedures in Flint, and

Oakland County doctors organized a march on the state Capitol. They are concerned about the dramatic increases in the costs of liability insurance.

In 1962, an orthopedic surgeon could obtain $1 million in medical malpractice insurance for approximately $362 a year. Today, that same policy costs an average of $69,000 a year. The cost for just $200,000 worth of coverage averages $48,000 a year, according to the Michigan Osteopathic Academy of Orthopedic Surgeons.

Those costs reflect the upward spiral in medical malpractice lawsuits. The Medical Protective Services Co., which writes malpractice policies, estimates that the frequency of medical malpractice claims has increased from 10 per 100 physicians in 1979 to 25 per 100 in 1984. Surely such an increase cannot be attributed solely or in any large part to decreasing medical skills on the part of Michigan doctors. That company, which insures 4,000 doctors in Michigan, has threatened to leave the state unless the medical malpractice crisis is curbed.

The high-risk categories of medical care are the most seriously affected by the crisis. Those specializing in obstetrics, orthopedic surgery, intensive care techniques, neurosurgery and neo-natal care are among the most dramatically affected.

Said one orthopedic surgeon during testimony: "The media has portrayed doctors to be able to accomplish miracles and miracles are what the patient wants." Anything less is increasingly viewed as malpractice. An increase in the trend will result in fewer and fewer doctors willing to achieve the miracle.

Another concern is that older, more established and more experienced doctors are leaving the state, dropping their specialty or quitting medicine altogether much earlier these days. Their legacy, not only to the patients, but also to medical students and young doctors, is eroding.

Medical malpractice insurance costs have more than doubled in the past five years, and have tripled and quadrupled in some specialties. The average cost for a Michigan doctor is estimated to be at least $52,000 per year, according to the Michigan Hospital Association. A hospital can pay approximately $7,000 to $8,000 per bed! The average premium increase in 1984 alone was 30.7 percent; in 1985, premiums increased 47 percent.

Other states, which have passed laws to limit malpractice cases and awards, like Indiana and Ohio, do not face as extreme a crisis. In 1980, Indiana passed comprehensive legislation putting a total cap on malpractice damages at $500,000 in structured payments, set a two-year statute of limitations and created a pre-screening panel.

The average malpractice premium for an obstetrician in Indiana is $6,000 compared to over $40,000 in Michigan. A general surgeon in Indiana pays about $5,000 a year in malpractice insurance. A Michigan colleague in the same field will pay at least 5.5 times more. It could go higher. In New York, California and Florida, premiums often exceed $80,000 a year.

Today, more and more specialists are taking up general practice and there is a reduced access to specialized services. Another major problem is that doctors are scheduling a superfluous number of tests, just to "be on the safe side." In fact, that so-called "defensive medicine" is estimated to cost patients more then $15 billion a year nationwide.

In Michigan, the Detroit metropolitan area has been hit the hardest by this problem, with Wayne County suffering the most. In fact, a recent story in the Detroit News cited the phenomenon of "carpetbagger" cases -- plaintiffs specifically requesting that their cases be tried in Wayne County because of high awards.

In the tri-county area of Wayne, Oakland and Macomb, the number of medical malpractice suits filed increased from just over 200 in 1970 to nearly

2,200 in 1984. An increase of 1100 percent in 14 years! Perhaps it is for many, as Attorney General Frank Kelley said, an opportunity to participate in the "second Michigan lottery."

It would be unwise, in fact impossible, to deny the extent of this plight which is adversely affecting patient and doctor alike in Michigan. The Senate Select Committee on Civil Justice Reform is ready to introduce legislation to address these problems. Their recommendations will be identified in the main body of this report.

GOVERNMENT LIABILITY

Few tears are shed about the prospect of "government" being sued for damages. Yet dramatic increases in these suits in recent years are escalating the costs of providing government services today and the taxpayer pays the inevitable price. Governments are being sued for improper road construction and maintenance, injuries on school playgrounds, unlit lamp posts, faulty stoplights, actions of public officials, high-speed police chases, improperly supervised public swimming pools, fires in empty state buildings, and just about every imaginable kind of liability. One major jury award could conceivably match or exceed a small community's annual budget for services.

The state of Michigan itself is a frequent target in the liability crisis. Though the state wins most of the lawsuits in which it is involved, the expense of defending the state in court is rapidly becoming a major factor in the state budget. Lawsuits against the state cost taxpayers over $26 million in settlements and judgments in the last fiscal year -- a third straight record and 33 percent over the previous year.

Michigan has a backlog of 1,400 suits representing claims of $2.4 billion -- about half of the general fund budget. Because of the perception

will have to pay pre-judgment interest from the date of filing. On the other hand, the plaintiff will have reduced incentive to turn down a reasonable settlement because the pre-judgment interest would not continue to run.

9. Expert Witness

Recommendation

RESTRICTIONS ON EXPERT TESTIMONY THAT SETS STANDARDS FOR QUALIFICATION OF EXPERT WITNESSES. WITH RESPECT TO AN ACTION AGAINST A NON-SPECIALIST, THERE MUST BE A REQUIREMENT THAT THE WITNESS MUST DEVOTE NOT LESS THAN 75 PERCENT OF HIS/HER PROFESSIONAL TIME TO THE ACTIVE CLINICAL PRACTICE OF MEDICINE OR TEACHING. IF THE ACTION IS AGAINST A SPECIALIST, THE WITNESS MUST ALSO BE REQUIRED TO SPECIALIZE IN THE SAME AREA OF MEDICINE AS THE DEFENDANT AND MUST DEVOTE NOT LESS THAN 75 PERCENT OF HIS/HER TIME TO ACTIVE CLINICAL PRACTICE OR TEACHING IN THE SAME SPECIALTY AS THE DEFENDANT.

Justification

This reform is necessary to regulate the use of "professional expert" witnesses in Michigan malpractice cases.

Testimony of expert witnesses is normally required to establish a cause of action for malpractice. Expert testimony is necessary to establish both the appropriate standard of care and the breach of that standard. There is currently no specific requirement for an expert witness to devote a specific percentage of time in the actual practice of medicine or teaching, or when testifying against a specialist that the expert actually practices or teaches in that specialty. Instead, a physician-witness is qualified to testify as an expert in Michigan, even though he/she does not practice in Michigan and is not of the same specialty, based on a mere showing of an acceptable background and a familiarity with the nature of the medical condition involved in the case. As a practical matter, in many courts merely a license to practice medicine is needed to become a medical expert on an issue.

This has given rise to a group of national professional witnesses who travel the country routinely testifying for plaintiffs in malpractice actions.

These "hired guns" advertise extensively in professional journals and compete fiercely with each other for the expert witness business. For many, testifying is a full-time occupation and they rarely actually engage in the practice of medicine. There is a perception that these so-called expert witnesses will testify to whatever someone pays the to testify about.

This proposal is designed to make sure that expert witnesses actually practice or teach medicine. In other words, to make sure that experts will have firsthand practical expertise in the subject matter about which they are testifying. In particular, with the malpractice crisis facing high-risk specialists, such as neurosurgeons, orthopedic surgeons and ob/gyns, this reform is necessary to insure that in malpractice suits against specialists the expert witnesses actually practice in that same specialty. This will protect the integrity of our judicial system by requiring real experts instead of "hired guns."

10. Hospital and Doctor Record Keeping

Recommendation

A. AMEND THE PENAL CODE TO MAKE IT A CRIMINAL MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR UP TO ONE YEAR AND A MAXIMUM FINE OF $5,000, OR BOTH, FOR A HEALTH CARE PROVIDER TO HAVE WILLFULLY AND WRONGFULLY CHANGED, DESTROYED, ALTERED, OR TAMPERED WITH MEDICAL RECORDS OR CHARTS.

B. AMEND THE PENAL CODE TO MAKE IT A CRIMINAL MISDEMEANOR PUNISHABLE BY IMPRISONMENT FOR UP TO ONE YEAR AND A MAXIMUM FINE OF $5,000, OR BOTH, FOR A HEALTH CARE PROVIDER TO INTENTIONALLY, WILLFULLY, OR RECKLESSLY PROVIDE MISLEADING OR INACCURATE INFORMATION TO A PATIENT REGARDING THE DIAGNOSIS, TREATMENT OR CAUSE OF A PATIENT'S CONDITION, OR TO PLACE SUCH INFORMATION IN A PATIENT'S MEDICAL RECORD OR HOSPITAL CHART.

C. REQUIRE HOSPITALS TO MAINTAIN ACCURATE AND COMPLETE PATIENT RECORDS AND DOCUMENTATION, AND TO TAKE PRECAUTIONS SO THAT SUCH RECORDS ARE NOT CHANGED, DESTROYED, ALTERED OR TAMPERED. THE FAILURE OF THE HOSPITAL TO COMPLY MAY RESULT IN A CIVIL FINE OF $5,000.

APPENDIX B

te Fiscal Agency
Box 30036
ng, Michigan 48909-7536

SFA BILL ANALYSIS

Telephone: (517) 373-5383
Fax: (517) 373-1986
TDD: (517) 373-0543

Senate Bill 270
Sponsor: Senator Dan L. DeGrow
Senate Committee: Judiciary
House Committee: Judiciary

Date Completed: 8-11-93

PUBLIC ACT 78 of 1993

MASTER FILE

SUMMARY OF SENATE BILL 270 as enrolled:

The bill would amend the Revised Judicature Act (RJA) to implement certain revisions in medical liability determination procedures. The bill would do all of the following:

- **Provide for a cap of $280,000--or $500,000 if certain exceptions applied--on the total amount of noneconomic damages recoverable by all plaintiffs in a medical malpractice action.**
- **Revise the RJA's regulations on the use of an expert witness in a medical malpractice action.**
- **Require a 182-day notice before a medical malpractice action could be commenced; require a response to that notice within 154 days; and require each party to give the other access to related medical records in the party's control.**
- **Require all medical malpractice plaintiffs to file an affidavit of merit, and require all defendants to file an affidavit of meritorious defense.**
- **Permit the binding arbitration of medical malpractice actions involving damages of $75,000 or less, and repeal current provisions on health care arbitration.**
- **Require parties settling a medical malpractice action to file a copy of the settlement agreement with the Department of Commerce.**
- **Revise the statute of limitations (SOL) for certain medical malpractice claims.**
- **Make other provisions pertaining to: burden of proof; waiver of a plaintiff's physician-patient privilege; and interest on judgments.**

Award Cap

Under the RJA, damages for noneconomic loss that result from a medical malpractice claim are limited to $225,000, except in cases involving a death; an injury involving the patient's reproductive system; the loss of a vital bodily function; an intentional tort; and circumstances under which a foreign object was left in a patient's body, a health care provider's fraudulent conduct prevented the discovery of a claim, or a patient's limb or organ was wrongfully removed. ("Noneconomic loss" means "damages or loss due to pain, suffering, inconvenience, physical impairment, physical disfigurement, or other noneconomic loss".)

The bill provides, instead, that the total amount of damages for noneconomic loss recoverable by all plaintiffs, resulting from the negligence of all defendants, could not exceed $280,000. The total amount of noneconomic damages could not exceed $500,000, however, if as the result of the negligence of one or more of the defendants, any of the following exceptions applied as determined by the court:

- The plaintiff was hemiplegic, paraplegic, or quadriplegic resulting in a total permanent functional loss of one or more limbs caused by brain and/or spinal cord injury.
- The plaintiff had permanently impaired cognitive capacity rendering him or her incapable of making independent, responsible life decisions and permanently incapable of independently performing

the activities of normal, daily living.
-- There had been permanent loss of or damage to a reproductive organ resulting in the inability to procreate.

The court would be required to reduce an award in excess of either of the proposed limitations to the amount of the appropriate limitation. Neither the court nor counsel for either party could advise the jury of these limitations or any of the law's provisions concerning noneconomic damages.

Under the RJA, the noneconomic loss limit must be "increased" annually by an amount determined by the State Treasurer to reflect the cumulative annual percentage "increase" in the consumer price index (CPI). The bill provides, instead, that the State Treasurer would have to "adjust" the noneconomic loss limit to reflect the "change" in the CPI.

Expert Witnesses

In an action alleging medical malpractice, the RJA prohibits a person from giving expert testimony on the appropriate standard of care, if the defendant is a specialist, unless the expert witness is a "physician licensed to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry" in Michigan or another state and is a specialist in the same or a related, relevant area as the defendant. An expert witness also must devote, or have devoted at the time of the occurrence in question, a "substantial portion" of his or her professional time to clinical practice or the instruction of students in the same or a related specialty at an accredited medical, osteopathic, or dental school.

The bill, instead, would require that an expert witness be a licensed "health professional" in Michigan or another state. If the party against whom or on whose behalf the witness offered testimony were a specialist, the expert witness would have to specialize in the same specialty as the party. If the party were a board-certified specialist, the expert witness also would have to board-certified in that specialty.

In addition, during the year immediately preceding the date of the occurrence in question, the expert witness would have to have devoted a majority of his or her professional time to either or both of the following:

-- The active clinical practice of the same health profession in which the party was licensed and, if the party were a specialist, active clinical practice in that specialty.
-- The instruction of students in an accredited health professional school or accredited residency or clinical research program in the same profession in which the party was licensed and, if the party were a specialist, in an accredited health professional school or accredited residency or clinical research program in the same specialty.

If the party against whom or on whose behalf the witness offered testimony were a general practitioner, the expert witness, during the year immediately preceding the date of the occurrence in question, would have to have devoted a majority of his or her professional time to active clinical practice as a general practitioner, and/or to instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession in which the party was licensed.

All of the following limitations would apply to discovery conducted by opposing counsel to determine whether an expert witness was qualified:

-- Tax returns of the expert would not be discoverable.
-- Family members of the expert could not be deposed concerning the amount of time he or she spent engaged in the practice of his or her health profession.
-- A personal diary or calendar (one not including listings or records of professional activities) belonging to the expert would not be discoverable.

Notice/Access to Records/Response

Notice. A person could not commence a medical malpractice action against a health professional or health facility, unless he or she gave the professional or facility written notice of the action at least 182 days before filing the action. The notice of intent to file a claim would have to be mailed to the last known professional business address or residential address of the health professional or health facility. Proof of the mailing would constitute prima facie

evidence of compliance with these requirements. If no last known professional business or residential address could be reasonably ascertained, notice could be mailed to the health facility where the care that was the basis for the claim was rendered.

The 182-day notice period would be shortened to 91 days if all of the following conditions existed:

- The claimant had previously filed the 182-day notice against other health professionals or health facilities involved in the claim.
- The 182-day notice period had expired as to the other health professionals or facilities.
- The claimant had filed a complaint and commenced a medical malpractice action against one or more of the other health professionals or health facilities.
- The claimant did not identify, and could not reasonably have identified a health professional or facility to which notice had to be sent as a potential party to the action before filing the complaint.

The notice given to a health professional or facility would have to state at least all of the following:

- The factual basis for the claim.
- The applicable standard of practice or care alleged by the claimant.
- The manner in which it was claimed that the applicable standard was breached.
- The alleged action that should have been taken to achieve compliance with the alleged standard.
- The manner in which it was alleged the breach was the proximate cause of the injury claimed.
- The names of all health professionals and facilities the claimant was notifying in relation to the claim.

After the initial notice was given to a health professional or facility, the tacking or addition of successive 182-day periods would not be allowed, irrespective of how many additional notices were subsequently filed for that claim or the number of health professionals or facilities notified.

Records. Within 56 days after giving notice, the claimant would have to allow the health professional or facility access to all of the medical records related to the claim that were in the claimant's control, and would have to furnish releases for any medical records related to the claim that were not in the claimant's control, but of which he or she had knowledge. Within 56 days after receiving notice, the health professional or facility would have to give the claimant access to all medical records related to the claim that were in the control of the health professional or facility. These provisions would not restrict a health professional or facility receiving notice from communicating with other health professionals or facilities and acquiring medical records as permitted by the bill. These provisions would not restrict a patient's right of access to his or her medical records under any other provision of law.

Response. With 154 days after receiving notice, the health professional or facility against whom the claim was made would have to give the claimant or his or her authorized representative a written response that stated each of the following:

- The factual basis for the defense to the claim.
- The standard of practice or care that the health professional or facility claimed to be applicable to the action and that the professional or facility complied with that standard.
- The manner in which it was claimed that there was compliance with the applicable standard.
- The manner in which the health professional or facility contended that the alleged negligence was not the proximate cause of the claimant's alleged injury or damage.

Commencement of Action. If the claimant did not receive the written response within the 154-day period, he or she could commence an action alleging medical malpractice upon the expiration of that period.

If at any time during the applicable notice period a health professional or facility receiving notice informed the claimant in writing that the professional or facility did not intend to settle the claim within the applicable notice period, the claimant could commence a medical malpractice action against the professional or facility, as long as the claim was not barred by the statute of limitations.

Affidavit of Merit

In a medical malpractice action, the RJA requires that a complaint be accompanied either by security for costs or by an affidavit. The security may take the form of a bond with surety or any other equivalent security approved by the court, including cash in an escrow account, for costs in an amount of $2,000. An affidavit may be filed by the plaintiff or the plaintiff's attorney and must attest that the plaintiff or attorney has obtained a written opinion from a licensed physician, dentist, or other appropriate licensed health care provider that the claim alleged is meritorious.

The bill would delete the provisions pertaining to security for costs and revise the provisions requiring an affidavit. Under the bill, a medical malpractice plaintiff or plaintiff's attorney would have to file with the complaint an affidavit of merit signed by a health professional whom the plaintiff's attorney reasonably believed met the proposed requirements for an expert witness. The affidavit of merit would have to certify that the health professional had reviewed the notice and all medical records supplied to him or her by the plaintiff's attorney concerning the allegations contained in the notice, and state each of the following:

- The applicable standard of practice or care.
- The health professional's opinion that the applicable standard was breached by the health professional or facility receiving the notice.
- The actions that should have been taken or omitted by the health professional or facility in order to have complied with the applicable standard.
- The manner in which the breach of the standard was the proximate cause of the alleged injury.

Upon motion of a party for good cause shown, the court could grant the plaintiff or plaintiff's attorney an additional 28 days in which to file the affidavit.

If the defendant failed to allow access to medical records within the time period set forth above, the affidavit of merit could be filed within 91 days after the complaint was filed (rather than with the complaint).

Affidavit of Meritorious Defense

Currently, the RJA provides that, within 21 days after a plaintiff furnishes security or files an affidavit, the defendant must file an answer to the complaint. Within 91 days after filing an answer, the defendant must furnish security for costs or file an affidavit attesting that the defendant or defendant's attorney has obtained a written opinion from a licensed physician, dentist, or other appropriate licensed health care provider that there is a meritorious defense to the claim.

The bill would delete reference to security for costs and revise the affidavit requirements. Under the bill, the defendant would have to file an affidavit of meritorious defense signed by a health professional whom the defendant's attorney reasonably believed met the proposed requirements for an expert witness. The affidavit would have to certify that the health professional had reviewed the complaint and all medical records supplied to him or her by the defendant's attorney concerning the allegations in the complaint, and state each of the following:

- The factual basis for each defense to the claims made against the defendant in the complaint.
- The standard of practice or care that the defendant health professional or facility claimed to be applicable to the action and that the health professional or facility complied with that standard.
- The manner in which it was claimed by the defendant that there was compliance with the applicable standard.
- The manner in which the defendant contended that the alleged injury or damage was not related to the care and treatment rendered.

The affidavit of meritorious defense would have to be filed within 91 days after the plaintiff's affidavit of merit was filed. If the plaintiff failed to allow access to medical records as required, however, the affidavit of meritorious defense could be filed within 91 days after an answer to the complaint was filed.

Binding Arbitration

At any time after notice of intent to file a claim was given, if the total amount of damages claimed were $75,000 or less, including interest

and costs, all claimants and all health professionals or health facilities notified could agree in writing to submit the claim to binding arbitration. An arbitration agreement entered into under these provisions would have to contain at least all of the following provisions:

- A process for the selection of an arbitrator.
- An agreement to apportion the costs of the arbitration.
- A waiver of the right to trial.
- A waiver of the right to appeal.

The claimants giving notice and the health professionals or facilities receiving notice could agree in writing to a total amount of damages greater than the limit set forth above.

Arbitration conducted under these provisions would be binding as to all parties who had entered into the written agreement. Arbitration would have to be summary in nature, the proceeding would have to be conducted by a single arbitrator chosen by agreement of all parties to the claim, and there could be no live testimony of parties or witnesses. The Michigan Court Rules pertaining to discovery would not apply, although all of the following information would have to be disclosed and exchanged between the parties upon a party's written request:

- All relevant medical records or medical authorizations sufficient to enable the procurement of all relevant medical records.
- An expert witness report or statement, but only if the party procuring the report or statement intended to or did furnish it to the arbitrator for consideration.
- Relevant published works, medical texts, and scientific and medical literature.
- A concise written summary prepared by a party or the party's representative setting forth the party's factual and legal position on the damages claimed.
- Other information considered by the party making the request to be relevant to the claim or a defense to the claim.

The arbitrator would have to conduct one or more prehearing telephone conference calls or meetings with the parties or their attorneys, for the purpose of establishing the orderly request for and exchange of information described above, and any other advance disclosure of information considered reasonable and necessary in the arbitrator's sole discretion. The arbitrator would have to set deadlines for the exchange or advance disclosure of information.

The arbitrator could issue his or her decision without holding a formal hearing based solely upon his or her review of the materials furnished by the parties. In his or her sole discretion and whether or not requested to do so by a party, the arbitrator could hold a hearing. A hearing would be limited solely to the presentation of oral arguments, subject to time limitations set by the arbitrator.

A written agreement to submit the claim to binding arbitration would be binding on each party signing the agreement and on his or her representatives, insurers, and heirs. An arbitration agreement signed on behalf of a minor or a person who was otherwise incompetent would be enforceable and would not be subject to disaffirmance or disavowal, if the minor or incompetent person were represented by an attorney at the time the agreement was executed.

The arbitrator would have to issue a written decision that stated at a minimum the factual basis for the decision and the dollar amount of the award. The arbitrator could not include costs, interest, or attorney fees in an award. A party could submit an arbitrator's award to a court of competent jurisdiction for entry of judgment on and enforcement of the award. An arbitration award could not be appealed.

Statute of Limitations

The RJA provides that an action involving a medical malpractice claim may be commenced at any time within the applicable period prescribed by the Act, or within six months after the plaintiff discovers, or should have discovered, the claim's existence, whichever is later. No claim, however, may be commenced later than six years after the date of the act or omission that is the basis for the claim, unless discovery of the claim were prevented by a health care provider's fraudulent conduct, a foreign object were left in the patient's body, or the injury involved the reproductive system. The bill would revise those exceptions by allowing a claim to be commenced later than six years after the date of the act or omission only if 1) there had been permanent

loss of or damage to a reproductive organ resulting in the inability to procreate; or 2) discovery of the claim's existence were prevented by the fraudulent conduct of the health care professional against whom the claim was made, the health facility against which the claim was made, or a named employee or agent of the health professional or facility.

Under the RJA, if a person is under 18 years old at the time he or she is first entitled to bring an action, the SOL applicable to his or her claim is suspended until one year after the disability of infancy is removed. The RJA specifies, however, that if a medical malpractice claim accrues to a person who is 13 years old or younger, an action based on the claim must be commenced on or before his or her 15th birthday. If the person is over 13 when the claim accrues, he or she is subject to the usual medical malpractice SOL. The bill provides, instead, that if a claim alleging medical malpractice accrued to a person who had not reached his or her eighth birthday, an action based on the claim would have to be commenced on or before his or her 10th birthday, or within the usual medical malpractice SOL, whichever was later. A person who was eight or older at the time a medical malpractice claim accrued would be subject to the limitation period otherwise applicable to that type of claim.

If, however, a person had not reached his or her 13th birthday at the time a medical malpractice claim accrued to the person, and the claim involved an injury to the person's reproductive system, an action based on the claim could not be brought unless it were commenced on or before the person's 15th birthday or within the period of limitations generally applicable to medical malpractice claims, whichever was later. If a person had reached his or her 13th birthday at the time a medical malpractice claim accrued, and the claim involved an injury to the person's reproductive system, the generally applicable SOL would apply.

The bill provides that the statute of limitations or repose would be tolled if, during the applicable notice period under the section requiring a notice of intent to file a claim, a claim would be barred by the statute of limitation or repose, for not longer than a number of days equal to the number of days in the applicable notice period after the date notice was given in compliance with that section.

Other Provisions

Settlement Agreement. If a plaintiff in a medical malpractice action entered into a settlement agreement with a defendant concerning the action, whether or not the settlement was entered into under court supervision, and the defendant were licensed or registered under Article 15 of the Public Health Code, the plaintiff's attorney and the defendant's attorney, or, if the parties were not represented by attorneys, the plaintiff and the defendant, would be required jointly to file a complete written copy of the settlement agreement with the bureau within the Department of Commerce responsible for health occupations licensure, registration, and discipline, within 30 days after entering into the settlement agreement.

This information would be confidential except for use by the Department in an investigation, and would not be subject to disclosure under the Freedom of Information Act.

Burden of Proof. In a medical malpractice action, the plaintiff would have the burden of proving that he or she suffered an injury that more probably than not was proximately caused by the negligence of the defendant or defendants.

Loss of Opportunity. The plaintiff could not recover for loss of an opportunity to survive or an opportunity to achieve a better result unless the opportunity were greater than 50%.

Waiver of Physician-Patient Privilege. A person who gave notice of a medical malpractice claim or commenced a medical malpractice action would waive, for purposes of that claim or action, his or her physician-patient privilege with respect both to persons and entities involved in the acts, transactions, events, or occurrences that were the basis for the claim or action, and to those who provided care or treatment to the claimant or plaintiff in the claim or action for that condition or a condition related to the claim or action either before or after those acts, transactions, events, or occurrences, regardless of whether the person were a party to the action.

In order to obtain all information relevant to the subject matter of the claim or to prepare a defense, a person or entity who had received

notice of a medical malpractice claim or had been named as a defendant in a medical malpractice action, or that person's or entity's attorney or authorized representative, could communicate with a licensed health care professional or facility or a facility's employees. A person who disclosed information under this provision to a person or entity who had received notice of a medical malpractice claim or been named as a defendant in a medical malpractice action, or to that person's attorney or authorized representative, would not be in violation of a physician-patient privilege or any other similar duty or obligation created by law and owed to the claimant or plaintiff.

Interest. Interest on a money judgment would have to be calculated on the entire amount of the judgment, including attorney fees and other costs. The amount of interest attributable to that part of the judgment from which attorney fees were paid, however, would have to be retained by the plaintiff, and not paid to the plaintiff's attorney.

The RJA generally requires that a court order interest to be calculated from the date a complaint is filed to the date the judgment is satisfied. Under the bill, however, if the defendant in a medical malpractice action failed to allow access to medical records as required by the bill, the court would have to order that interest be calculated from the date that notice of intent to file a claim was given in compliance with the section requiring notice, to the date the judgment was satisfied. Further, if the plaintiff in medical malpractice action failed to allow access to medical records as required, the court would have to order that interest be calculated from 182 days after the date the complaint was filed to the date the judgment was satisfied.

Repeal. The bill would repeal provisions that permit a health care recipient to execute an agreement to arbitrate a dispute arising out of health care or treatment rendered by a health care provider or hospital, and that govern those arbitration proceedings (MCL 600.5040-600.5065).

Effective Date

The bill provides that it would take effect October 1, 1993.

Sections pertaining to noneconomic damages, burden of proof, recovery for loss of an opportunity, and the statute of limitations, as amended by the bill, would not apply to causes of action arising before October 1, 1993. Sections pertaining to expert testimony, affidavit of merit, affidavit of meritorious defense, interest, reduction of an award, and advising a jury of noneconomic damages limitations, as amended by the bill, would not apply to cases filed before that date.

Sections pertaining to waiver of the physician-patient privilege, notice of intent to file a claim, binding arbitration, and settlement agreements, as added or amended by the bill, would apply to causes of action arising on or after October 1, 1993, or cases filed on or after that date.

Tie-Bar

The bill is tie-barred to House Bills 4295, 4076, 4077, 4078, 4289, 4290, and 4292 (Public Acts 79 through 86 of 1993), which pertain to health professionals' disciplinary process.

MCL 600.1483 et al.

Legislative Analyst: S. Margules

FISCAL IMPACT

The bill's provisions that would limit malpractice suit award amounts and the number of malpractice suits filed would have some fiscal impact on the following State and local agencies that employ physicians and other health care professionals: the Department of Mental Health, Department of Corrections, the Veterans' Facilities, and local health departments. It is not possible to determine the extent of the fiscal impact at this time.

Fiscal Analyst: L. Nacionales-Tafoya

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This analysis was prepared by nonpartisan Senate staff for use by the Senate in its deliberations and does not constitute an official statement of legislative intent.

APPENDIX C

House
Legislative
Analysis
Section

Olds Plaza Building, 10th Floor
Lansing, Michigan 48909
Phone: 517/373-6466

MEDICAL MALPRACTICE LIABILITY

Senate Bill 270 (Substitute H-1)
Sponsor: Senator Dan L. DeGrow

House Bill 4033 (Substitute H-3)
Sponsor: Rep. David M. Gubow

House Bill 4403 (Substitute H-1)
Sponsor: Rep. Lynn Owen

House Bill 4404 (Substitute H-1)
Sponsor: Rep. Lynn Owen

Second Analysis (4-20-93)
Senate Committee (SB 270): Judiciary
House Committee (HB 4033): Mental Health
House Committee (other bills): Judiciary

THE APPARENT PROBLEM:

In 1986, the legislature enacted a series of reforms aimed at growing concerns about the effect of the medical liability system on the availability and affordability of health care in Michigan. Reforms that specifically addressed medical liability included limiting awards for noneconomic loss (that is, pain and suffering) to $225,000 (with exceptions), specifying qualifications for expert witnesses, constricting the statute of limitations for bringing a medical malpractice lawsuit, providing for the dismissal of a defendant upon an affidavit of noninvolvement, requiring mediation, and requiring each party either to provide security for costs or to file an affidavit of meritorious claim or defense.

Opinion is widespread in the medical community and elsewhere that these reforms have proved inadequate. Providers of medical care and malpractice insurance cite numerous statistics to support their case. For both doctors and hospitals, medical malpractice insurance costs much more in Michigan than elsewhere; Detroit area hospitals pay the highest liability rates in the country, and even smaller, outstate hospitals pay more than some urban hospitals elsewhere. The average liability cost per bed is $1,400 nationally, $4,600 for the state as a whole, and $6,900 in Detroit, while the $2,800 per bed average for rural Michigan is higher than figures cited for Chicago and Cleveland. A 1990 report of the U.S. Government Accounting Office (GAO) confirms that while rates declined in the nation and adjacent states since about 1988, Michigan rates have continued to increase, although at a slower rate since 1986.

Reports are that only 37 cents of each dollar spent on medical liability premiums goes to victims of malpractice, while roughly half of the money paid in premiums goes to legal fees (plaintiff and defense combined) and court costs. Payouts per claim are increasing; one hospital insurer reports a 173 percent increase--from $51,000 to $139,000--in its average payout per claim between 1986 and 1990. Lawsuits, too, are on the rise, threatening to widen the gap between Michigan and other states; nationally, about a half-dozen lawsuits are filed annually for every 100 physicians, but the figure for Michigan is closer to 20 lawsuits per 100 physicians.

Using survey results and anecdotal evidence, critics of the current system maintain that litigiousness and the high cost of insurance in Michigan drive out physicians, either literally out of the state, or out of practice through early retirement. Many other physicians choose to remain in practice, but eliminate costly elements such as obstetrics that carry a comparatively high risk for lawsuits (for example, obstetrical coverage in Detroit costs $134,000 annually for $1 million per occurrence/$3 million aggregate coverage; for $100,000/$300,000

coverage, the annual cost is $63,000). The medical liability climate thus is held at least partly responsible for problems that people in urban centers and rural areas have in obtaining medical care, and responsible for increasing health care costs by forcing physicians to practice "defensive medicine."

One thing that carries the potential to reduce the time and expense of malpractice lawsuits is the use of binding arbitration. However, existing arbitration provisions, which date to 1975, are little used; lack of participation has been attributed to patients' distrust of the current makeup of arbitration panels (which must have a physician as one of the three members), physician reluctance to serve on panels, the unwieldy process, and a lack of incentives to participate.

To alleviate problems with the state's medical liability system and address widespread dissatisfaction with it, further reforms have been proposed.

THE CONTENT OF THE BILLS:

Senate Bill 270 would amend the Revised Judicature Act (MCL 600.1483 et al.) to do the following with regard to medical malpractice actions: revise limits on noneconomic damages and link them to compliance with proposed financial responsibility requirements, limit attorneys' contingency fees, require expert witnesses to be of the same board-certified specialty or health profession as the defendant, bar a plaintiff from receiving payment for the loss of an opportunity to survive, require a plaintiff to notify a defendant 182 days before filing a suit, provide for the waiver of the physician-patient privilege when a malpractice suit is commenced, enact new provisions on voluntary binding arbitration, generally constrict the statute of limitations on suing for injuries done to minors, and eliminate the tolling (suspension) of the statute of limitations when a foreign object was left in the body.

The bill is tie-barred to House Bills 4033, 4403, 4404, and the "physician discipline" package (House Bills 4076, 4295, and companion bills). Generally speaking, provisions that are procedural in nature (such as those dealing with expert witnesses, arbitration, and the 182-day notice requirement) would apply to cases filed on or after October 1, 1993, while substantive provisions (such as those dealing with noneconomic loss limits and statutes of limitations) would apply to causes of action arising on or after October 1, 1993.

A more detailed explanation follows.

Noneconomic losses. The bill would replace the current $225,000 limit on noneconomic losses (which statutory adjustments for inflation have increased to a reported $280,000) and the exceptions to it with a two-tier limit. Generally, payment for noneconomic losses could not exceed $500,000. However, the limit would be $1 million if there had been a death, if there were a permanent disability due to an injury to the brain or spinal cord, if damage to a reproductive organ left a person unable to procreate, or if a medical record had been illegally destroyed or falsified. The award caps would be halved for a defendant who was in compliance with the financial responsibility requirements proposed by House Bill 4404. Caps would be annually adjusted for inflation.

Contingency fees. An attorney's contingency fee would be limited to 15 percent of the amount recovered if the claim was settled before mediation or arbitration, 25 percent if settled after mediation or arbitration but before trial, and 33-1/3 percent if the claim went to trial. (Court rules limit contingency fees to 33-1/3 percent.) The bill would prescribe the manner of computing the fee, require a contingency fee agreement to be in writing, and require an attorney to make certain disclosures regarding fees. An attorney whose contingency fee agreement provided for a contingency fee in excess of that allowed could not collect more than what would be received under his or her usual hourly rate of compensation, up to the amount provided by the applicable contingency fee limit.

Expert witnesses. At present, if the defendant physician or dentist is a specialist, an expert witness must be of the same or related specialty and at the time devoting a substantial portion of his or her professional time to either active clinical practice or medical or dental school instruction. Under the bill, each expert witness (not just those in cases involving specialists) would have to have spent a substantial portion of the preceding year in active clinical practice in the same health profession as the defendant or in the instruction of students. If a defendant was board-certified, the witness would have to be, and if the defendant was a general

ıctitioner, the witness would have to ther be a ıeral practitioner or instructing students.

ither the tax returns nor the personal diary or endar of an expert witness could be sought or ed by counsel to determine whether an expert ness was qualified, and counsel would be bidden from interviewing the witness's family embers concerning the amount of time the witness ent engaged in his or her health profession.

st opportunity to survive. A plaintiff would be rred from recovering for a lost opportunity to rvive. (This would override the 1990 decision of e Michigan Supreme Court in Falcon v. Memorial ospital, 436 Mich. 443. In that case, the court ld that in medical malpractice actions, loss of an portunity to survive is compensable in proportion the extent of the lost opportunity, even though e opportunity was less than fifty percent and it as not probable that an unfavorable result would could have been avoided. Under this decision, e plaintiff must establish that the defendant more obably than not reduced the opportunity of oiding harm.)

dvance notice of suit. For the stated purposes of romoting settlement without the need for formal tigation, reducing the cost of medical malpractice tigation, and providing compensation for ıeritorious medical malpractice claims that would therwise be precluded from recovery because of tigation costs, the bill would require a plaintiff lanning to file suit to notify a defendant at least 82 days before commencing court action. The ıotice could be filed later if a statute of limitations vas about to apply. Meeting the 182-day equirement for one defendant would cover meeting t for any future defendants added to the suit. The ıotice would have to contain certain minimum nformation about the case and its basis.

The claimant and the defendant would have to give each other access to each other's medical records within 91 days after the notice. A defendant's failure to allow timely access to records would be penalized under provisions regarding affidavits of merit and interest on judgments (see below). Within 126 days after the notice, the defendant would have to furnish the claimant with a written response with certain information about the defense; failure to provide the information on time would entitle the claimant to file suit immediately.

Affidavits of merit. Existing law requires plaintiffs and defendants either to post a $2,000 bond or other financial security for payment of costs, or to file an affidavit of meritorious claim or defense. The bill would delete provisions allowing security for costs to be filed in lieu of an affidavit. Affidavits would have to contain information on the basis and allegations of the case, as prescribed by the bill (this information would parallel that to be exchanged under the 182-day notice provisions). If the defendant failed to allow access to medical records as required by the 182-day notice provisions, a plaintiff's affidavit could be filed 91 days after the complaint.

Professional privilege. Someone claiming malpractice would be considered to have waived the physician-patient privilege or similar privilege with respect to a person or entity who was involved, whether or not that person was a party to the claim or action. A defendant could communicate with other health facilities or professionals to obtain relevant information and prepare a defense; disclosure of that information to the defendant would not constitute a violation of the physician-patient privilege.

Arbitration. The bill would repeal Chapter 50a of the act, which provides for arbitration of medical malpractice lawsuits, and replace it with provisions for voluntary binding arbitration that would apply to cases where damages claimed amounted to $75,000 or less, including interest and costs. The bill's arbitration procedures would be available during the 182-day notice period (that is, after notice was given but before a case was filed). Unlike current law, which calls for an arbitration panel consisting of a doctor, a lawyer, and someone who is neither, under the bill the parties would agree to a process for the selection of a single arbitrator. The arbitration agreement would also apportion the costs of the arbitration and contain waivers of the right to trial and appeal; defendants would waive the question of liability. The parties could agree to a total amount of damages greater than $75,000.

There would be no live testimony, and court rules on discovery would not apply, although certain information would have to be exchanged upon request under deadlines established by the arbitrator. The arbitrator could issue the decision with or without holding a formal hearing, although he or she would have to conduct at least one telephone conference call or meeting with the

parties. If there was a hearing, it would have to be limited to presentation of oral arguments. The arbitrator would issue a written decision stating the factual basis for it and the amount of any award. There would be no right to appeal the award.

Settlements. If a case was settled (with or without court supervision), the parties would have to file a copy of the settlement agreement with the appropriate bureau of the Department of Commerce. The information would be confidential except for use by the department in an investigation; it would not be subject to the Freedom of Information Act.

Mediation. Current law provides for mediation of medical malpractice suits. Under the bill, if a defendant rejected a mediation panel's evaluation, but the plaintiff did not, and the case went to trial, the defendant's insurer would be liable for the plaintiff's costs unless the verdict was more favorable to the defendant than the mediation evaluation.

Statute of limitations--general. Generally, a medical malpractice action must be commenced within two years after the injury was caused, or six months after it was or should have been discovered, whichever was later; however, in no event may it be commenced more than six years after the injury was caused. However, for certain injuries, this six-year statute of repose does not apply; the bill would eliminate an exception for situations where a foreign object was wrongfully left in the patient's body, and limit an exception for reproductive injuries to those where there was a loss of the ability to procreate in someone under 35 years old. An exception for fraudulent conduct of a health care provider would be retained. Giving 182-day notice as required by the bill would toll (suspend the running of) the statute of limitations.

Statute of limitations--minors. The running of the statute of limitations is suspended until someone reaches age 13. For injuries to a child that occur before age thirteen, action must be commenced by the time the child reaches age 15; after age 13 the regular medical malpractice statute of limitations applies. Under the bill, the running of the statute of limitations would be suspended until a child reached age 10, and an action for a child under that age would have to be commenced before the child's twelfth birthday, or within the regular medical malpractice period of limitations, whichever was later (the six-year statute of repose would not apply).

However, if an injury to the reproductive system of someone under age 13 was claimed, the claim would have to be brought before his or her fifteenth birthday or before the regular medical malpractice statute of limitations would apply, whichever was later (the six-year statute of repose would not apply).

Interest on judgments. The law now provides for the calculation and payment of interest on judgments. Under the bill, if a medical malpractice defendant failed to allow access to records as required by the 182-day notice provisions, the court would order that interest be calculated from the date notice was given to the date of satisfaction of the judgment. The injured party, and not his or her attorney, would receive the interest accruing on the portion of a judgment represented by the attorney's fee.

House Bill 4403 would amend the Insurance Code (MCL 500.2204) to require an commercial liability insurer to pay the plaintiff's attorney fees and court costs when an insured defendant had rejected a mediation evaluation under the Revised Judicature Act, the plaintiff had not rejected it, and the case went to trial. However, the payment requirement would not apply if the verdict was more favorable to the defendant than the mediation evaluation. The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4404 would amend the Public Health Code (MCL 333.16280 and 333.21517) to require each physician, dentist, psychologist, chiropractor, and podiatrist to maintain financial responsibility for medical malpractice actions. The financial responsibility would have to be one of the following: a $200,000 surety bond or irrevocable letter of credit; an escrow account containing at least $200,000 in cash or unencumbered securities; or professional liability insurance coverage with limits of at least $200,000 per claim and $600,000 in the aggregate.

Someone licensed on or before October 1, 1993 would have to file proof of financial responsibility with his or her licensing board by January 1, 1994. Others would have to file proof within 90 days after the issuance of a license. After the initial filing, proof would have to be filed annually.

Financial responsibility requirements would not apply to someone with a hospital affiliation, if the hospital provided the equivalent amount of financial responsibility. However, if the person practiced outside of the hospital, he or she would have to maintain financial responsibility for that portion of his or her practice performed outside the hospital. Financial responsibility requirements would not apply to someone whose practice outside of a hospital consisted of at least 25 percent uninsured and Medicaid patients, based on the total number of patients treated annually by the person. Proof of such a practice would have to be filed with the person's board.

A hospital would be prohibited from granting privileges to a physician unless financial responsibility requirements were met. Compliance with the bill would not be a condition of licensure for a physician or other person required to maintain financial responsibility.

The bill could not take effect unless Senate Bill 270 was enacted.

House Bill 4033 would amend the Mental Health Code to forbid a licensee under the code (a mental hospital, psychiatric hospital, or psychiatric unit) from granting privileges to physician who was not in compliance with the financial responsiblity requirements of House Bill 4404, unless the licensee covered the physician as allowed by House Bill 4404. The bill could not take effect unless Senate Bill 270 was enacted.

HOUSE COMMITTEE ACTION:

The House Judiciary Committee adopted a substitute for Senate Bill 270 that differed from the Senate-passed bill in proposing new provisions on arbititration, and linking medical malpractice reform to requirements for financial responsibility. The substitute's provisions on contingency fees, noneconomic losses, expert witnesses, and the statute of limitations also differed from those in the Senate-passed version.

FISCAL IMPLICATIONS:

Fiscal information is not available at present.

ARGUMENTS:

For:

The bills would go far to discourage unjustified medical malpractice lawsuits and reduce the costs of the medical malpractice liability system, thus helping to contain spiraling health care costs, stem the flight of physicians out of Michigan, and assure the citizens of this state access to affordable health care. Stricter limits on pain and suffering awards, limits on contingency fees, early notice requirements, and new arbitration provisions would reduce litigation costs by encouraging arbitration and early settlement and curbing excessive awards.

New limits on pain and suffering awards and the medical malpractice statute of limitations would further help to reduce insurance costs by addressing the uncertainties and long period of exposure in this highly volatile area of insurance. Without such measures and controls on the costs of litigation, there is little to be done to reduce premiums, for neither they nor profits are inflated: the major malpractice insurers are customer-owned (that is owned by physicians or hospitals), and the insurance bureau reports a healthy degree of competition in the marketplace.

Victims of medical malpractice would not be ignored, however: requirements for physicians to maintain financial responsibility, provisions on payment of judgment interest, and incentives to arbitrate small suits that might otherwise go begging for legal representation all would help to put money in injured patients' pockets. Links to the physician discipline package would recognize the need to also protect patients by reducing the incidence of malpractice. And, eventually, the bills would help patients by holding back health care costs, and not only through effects on premiums; far greater savings are likely through easing physicians' litigation fears, thus reducing the need to practice "defensive medicine" which drives up the cost of health care through the use of high technology and second opinions.

The bills offer a balanced compromise that should streamline the system to the ultimate benefit of both patients and health care providers.

Against:
Many dispute whether there really is any sort of malpractice "crisis" that demands resolution, especially a resolution that restricts legal recourse for victims of malpractice. If Michigan has more than its share of malpractice lawsuits, it is because Michigan ranks low in its effectiveness in getting bad doctors out of business, and because insufficient attention has been devoted to risk management in hospitals, where the vast majority of malpractice claims arise. If insurance costs too much, it is because insurers are charging too much; profits are up in recent years, but premiums continue to rise. More carriers are writing malpractice insurance in Michigan, and availability problems have decreased.

The numbers of physicians are up, not down, thus countering assertions that Michigan's malpractice climate has led to problems in obtaining care. Moreover, it is unreasonable to hold the medical malpractice system responsible for the lack of health care for residents of poor urban and rural areas of Michigan; recruiting doctors to such places is a problem across the country, and has long been so.

If rising costs of health care are a real concern, then attacking the medical liability system would have little effect: insurance premiums represent only one or two percent of total health care costs, and "defensive medicine" habits are unlikely to be affected (nor should they, say some, as the caution and thoroughness that characterize "defensive" medicine also characterize good medicine).

Virtually every assertion made by the proponents of medical liability reform has been challenged with conflicting data. Many believe the picture is not as clear as some present it, and urge restraint before prematurely assuming the reforms of 1986 need strengthening. Rather than again taking aim at the victims of malpractice, reformers should first look to the defects of the insurance and physician discipline systems.

Against:
While the reforms are a step in the right direction, they do not go far enough. Overly broad exceptions to caps on noneconomic awards would continue to allow half or more of major cases to get out from under the limits, as the language could be stretched to allow the exemption of many relatively minor injuries. A permanent limp, for example, could be argued to meet the exception for permanent disability.

Contingency fee provisions also are inadequate: without firm limits on attorneys' financial incentives to seek windfall awards in marginal cases, case filings are unlikely to decline. Worse, the proposed sliding scale would give attorneys an incentive to push for trial by giving them a bigger take than if they settled out of court or accepted arbitration.

Finally, Senate Bill 270 would do nothing to rid the system of professional witnesses. By allowing expert witnesses to qualify if they spend a "substantial portion" of their time in the necessary fields, the bill would continue to allow justice to be subverted by traveling "guns for hire."

Against:
Limits on contingency fees raise a number of constitutional issues. Being a matter of practice and procedure, contingency fees are properly within the constitutionally-determined purview of the supreme court, and are at present set by supreme court rule. An attempt to regulate contingency fees in statute would conflict with the court's constitutional rule-making authority and the doctrine of separation of powers. Statutory limits on plaintiffs' attorney fees may also violate constitutional provisions for equal protection, if defendants' fees are not also regulated. Finally, by inserting itself into a matter that is between attorney and client, Senate Bill 270 may intrude on the right to contract.

Against:
A major problem with the current state of affairs is the heavy financial burdens that a physician must assume to practice in Michigan. Rather than ease those burdens, the legislation would add to them by requiring physicians to maintain a specified form of financial responsibility or lose hospital privileges. The financial responsibility requirements would tend to exacerbate problems with physicians leaving practice in Michigan.

POSITIONS:

The State Bar of Michigan opposed Senate Bill 270 as passed by the Senate, has concerns about the constitutionality of provisions on contingency fees, and is supportive of portions of the House substitute. (3-30-93)

Michigan Trial Lawyers Association does not rt the package. (3-30-93)

Advocacy Organization for Patients and lers does not believe the package will resolve roblem, in part because it is not linked to nce reform. (3-30-93)

ians Insurance Company of Michigan)M) opposes the package, but could support amendments. (3-30-93)

Michigan Medical Liability Reform Coalition es the bills. (3-30-93) Organizations in the mber coalition include the following:

er Detroit Chamber of Commerce
gan Association for Local Public Health
gan Association of Osteopathic Physicians and geons
gan Dental Association
gan Farm Bureau
gan Hospital Association
gan Hospital Association Mutual Insurance npany
gan Insurance Federation
gan Manufacturers Association
gan Physicians Mutual Liability Company
gan State Medical Society
ians Insurance Company of Michigan

APPENDIX D

Adopted 4/21/93
- superseded by (H-2)

HOUSE SUBSTITUTE FOR

SENATE BILL NO. 270

A bill to amend sections 1483, 2169, 2912a, 2912d, 2912e, 4921, 4969, 5838a, 5851, 5856, 6013, and 6304 of Act No. 236 of the Public Acts of 1961, entitled as amended "Revised judicature act of 1961," sections 1483, 2169, 2912d, 2912e, 4921, 4969, 5838a, and 6304 as added and section 5851 as amended by Act No. 178 of the Public Acts of 1986 and section 6013 as amended by Act No. 50 of the Public Acts of 1987, being sections 600.1483, 600.2169, 600.2912a, 600.2912d, 600.2912e, 600.4921, 600.4969, 600.5838a, 600.5851, 600.5856, 600.6013, and 600.6304 of the Michigan Compiled Laws; to add sections 955, 2912b, 2912f, 2912g, and 2912h; and to repeal certain parts of the act.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Section 1. Sections 1483, 2169, 2912a, 2912d, 2912e, 4921, 4969, 5838a, 5851, 5856, 6013, and 6304 of Act No. 236 of the

(5) ~~(4)~~ The STATE TREASURER SHALL ADJUST THE limitation on ~~noneconomic~~ damages FOR NONECONOMIC LOSS set forth in subsection (1) ~~shall be increased~~ by an amount determined by the state treasurer at the end of each calendar year to reflect the cumulative annual percentage ~~increase~~ CHANGE in the consumer price index. As used in this subsection, "consumer price index" means the most comprehensive index of consumer prices available for this state from the bureau of labor statistics of the United States department of labor.

Sec. 2169. (1) In an action alleging medical malpractice, ~~if the defendant is a specialist,~~ a person shall not give expert testimony on the appropriate standard of PRACTICE OR care unless the person is ~~or was a physician~~ licensed ~~to practice medicine or osteopathic medicine and surgery or a dentist licensed to practice dentistry~~ AS A HEALTH PROFESSIONAL in this STATE or another state and meets ~~both of~~ the following criteria:

(a) ~~Specializes, or specialized~~ IF THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED IS A SPECIALIST, SPECIALIZES at the time of the occurrence ~~which~~ THAT is the basis for the action ~~,~~ in the same OR A SUBSTANTIALLY SIMILAR specialty ~~or a related, relevant area of medicine or osteopathic medicine and surgery or dentistry as the specialist who is the defendant in the medical malpractice action~~ AS THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED. HOWEVER, IF THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED IS A SPECIALIST CERTIFIED BY THE AMERICAN BOARD OF

CERTIFICATION, THE EXPERT WITNESS MUST BE CERTIFIED BY THE AMERICAN BOARD OF CERTIFICATION IN THAT SPECIALTY.

(b) ~~Devotes, or devoted at the time~~ SUBJECT TO SUBDIVISION (C), DURING THE YEAR IMMEDIATELY PRECEDING THE DATE of the occurrence ~~which~~ THAT is the basis for the CLAIM OR action, DEVOTED a substantial portion of his or her professional time to EITHER OR BOTH OF the FOLLOWING:

(*i*) THE active clinical practice of ~~medicine or osteopathic medicine and surgery or the active clinical practice of dentistry, or to~~ the SAME HEALTH PROFESSION IN WHICH THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED IS LICENSED AND, IF THAT PARTY IS A SPECIALIST, THE ACTIVE CLINICAL PRACTICE OF THAT SPECIALTY.

(*ii*) THE instruction of students in an accredited ~~medical school, osteopathic medical school, or dental~~ HEALTH PROFESSIONAL school OR ACCREDITED RESIDENCY OR RESEARCH PROGRAM IN THE SAME HEALTH PROFESSION IN WHICH THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED IS LICENSED AND, IF THAT PARTY IS A SPECIALIST, AN ACCREDITED HEALTH PROFESSIONAL SCHOOL OR ACCREDITED RESIDENCY OR RESEARCH PROGRAM in the same OR A SUBSTANTIALLY SIMILAR specialty. ~~or a related, relevant area of health care as the specialist who is the defendant in the medical malpractice action.~~

(C) IF THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED IS A GENERAL PRACTITIONER, THE EXPERT WITNESS, DURING THE YEAR IMMEDIATELY PRECEDING THE DATE OF THE OCCURRENCE THAT IS THE BASIS FOR THE CLAIM OR ACTION, DEVOTED A SUBSTANTIAL PORTION OF HIS OR HER PROFESSIONAL TIME TO EITHER OR BOTH OF THE FOLLOWING:

(*i*) ACTIVE CLINICAL PRACTICE AS A GENERAL PRACTITIONER.

(*ii*) INSTRUCTION OF STUDENTS IN AN ACCREDITED HEALTH PROFESSIONAL SCHOOL OR ACCREDITED RESIDENCY OR RESEARCH PROGRAM IN THE SAME HEALTH PROFESSION IN WHICH THE PARTY AGAINST WHOM THE TESTIMONY IS OFFERED IS LICENSED.

(2) In determining the qualifications of an expert witness in an action alleging medical malpractice, the court shall, at a minimum, evaluate all of the following:

(a) The educational and professional training of the expert witness.

(b) The area of specialization of the expert witness.

(c) The length of time the expert witness has been engaged in the active clinical practice or instruction of ~~medicine, osteopathic medicine and surgery, or dentistry~~ THE HEALTH PROFESSION OR THE SPECIALTY.

(d) The relevancy of the expert witness's testimony.

(3) This section does not limit the power of the trial court to disqualify an expert witness on grounds other than the qualifications set forth in this section.

(4) In an action alleging medical malpractice, an expert witness shall not testify on a contingency fee basis. A person who violates this subsection is guilty of a misdemeanor.

(5) ~~As used in this section~~ IN AN ACTION ALLEGING MEDICAL MALPRACTICE, ALL OF THE FOLLOWING LIMITATIONS APPLY TO DISCOVERY CONDUCTED BY OPPOSING COUNSEL TO DETERMINE WHETHER OR NOT AN EXPERT WITNESS IS QUALIFIED:

(a) ~~"Practice of dentistry" means the practice of dentistry as defined in section 16601 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.16601 of the Michigan Compiled Laws~~ TAX RETURNS OF THE EXPERT WITNESS ARE NOT DISCOVERABLE.

(b) ~~"Practice of medicine" means the practice of medicine as defined in section 17001 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17001 of the Michigan Compiled Laws~~ FAMILY MEMBERS OF THE EXPERT WITNESS SHALL NOT BE DEPOSED CONCERNING THE AMOUNT OF TIME THE EXPERT WITNESS SPENDS ENGAGED IN THE PRACTICE OF HIS OR HER HEALTH PROFESSION.

(c) ~~"Practice of osteopathic medicine and surgery" means the practice of osteopathic medicine and surgery as defined in section 17501 of the public health code, being section 333.17501 of the Michigan Compiled Laws~~ A PERSONAL DIARY OR CALENDAR BELONGING TO THE EXPERT WITNESS IS NOT DISCOVERABLE.

Sec. 2912a. (1) ~~In~~ SUBJECT TO SUBSECTION (2), IN an action alleging malpractice, the plaintiff ~~shall have~~ HAS the burden of proving that in light of the state of the art existing at the time of the alleged malpractice:

(a) The defendant, if a general practitioner, failed to provide the plaintiff the recognized standard of acceptable professional practice OR CARE in the community in which the defendant practices or in a similar community, and that as a proximate result of the defendant failing to provide that standard, the plaintiff suffered an injury.